House of Representatives

General Assembly

File No. 306

February Session, 2008

Substitute House Bill No. 5721

House of Representatives, March 31, 2008

The Committee on Insurance and Real Estate reported through REP. O'CONNOR of the 35th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT ESTABLISHING THE CONNECTICUT HEALTHY STEPS PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2008*) Sections 1 to 9, inclusive, 11 to 21, inclusive, and 26 and 27 of this act, and subsection (a) of section 17b-192 of the 2008 supplement to the general statutes, section 17b-261 of the 2008 supplement to the general statutes, section 17b-267 of the general statutes, section 17b-292 of the 2008 supplement to the general statutes, and section 38a-567 of the general statutes, as amended by this act, shall be known as the Connecticut Healthy Steps program.

Sec. 2. (NEW) (*Effective July 1, 2008*) (a) There is established a permanent Health Care Reform Commission, which shall be an independent, nonprofit body within the Office of Health Care Access for administrative purposes only. The commission shall consist of the Comptroller, the Commissioners of Social Services, Public Health and Health Care Access and the Insurance Commissioner, or their

designees, and nine additional members appointed as follows: One by the Connecticut Medical Society; one by the Connecticut Hospital Association; one by the Connecticut Association of Health Plans; one by the Connecticut Business and Industry Association; two from consumer advocacy organizations, one of whom shall be appointed by the president pro tempore of the Senate and one of whom shall be appointed by the speaker of the House of Representatives; and three by the Governor, one of whom shall be an owner of a Connecticut business with fifty or fewer employees in the state, one of whom shall be an owner, senior manager or human resources director of a Connecticut business with more than fifty employees in the state, and one of whom shall be a senior manager or human resources director of a labor union that offers a Taft-Hartley plan.

(b) Notwithstanding the provisions of subsection (c) of section 4-9a of the general statutes, the nine additional appointed members of the commission shall serve for staggered terms. The initial members selected shall serve as follows from the date of appointment: (1) The members appointed by the Connecticut Hospital Association, the Connecticut Association of Health Plans and the Connecticut Business and Industry Association shall serve for three years; (2) the members appointed by the Connecticut Medical Society, the president pro tempore of the Senate and the speaker of the House of Representatives shall serve for two years; and (3) the members appointed by the Governor shall serve for one year. Following the expiration of such initial terms, each subsequent appointee shall serve for a term of three years. Any vacancy shall be filled by the appointing authority for the unexpired portion of the term of the member replaced. Members may be reappointed to serve consecutive terms. The members shall serve without compensation for their services but shall be reimbursed for their expenses.

(c) The commission shall:

(1) (A) Notwithstanding section 38a-553 of the general statutes, not later than April 1, 2009, design health benefit plans that shall be known

as affordable health care plans that meet the requirements of section 4 of this act and that shall be approved by the Insurance Commissioner, (B) not later than January 1, 2010, make such plans available for sale, and if any employer purchases such plan for its employees through the Connecticut Connector, as defined in section 3 of this act, or any other plan through the Connecticut Connector for its employees that is at least equivalent to the type and level of benefits of affordable health care plans, such employer shall qualify for a tax credit pursuant to section 27 of this act, and (C) adopt rules for the collection of fees in accordance with subdivision (4) of subsection (d) of section 3 of this act;

(2) Not later than October 1, 2010, submit a report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with section 11-4a of the general statutes, that identifies the effect of health insurance mandates under chapter 700c of the general statutes on health care premiums paid by private sector employers;

(3) Explore incentive options to encourage individuals to use health insurance responsibly;

(4) Determine the fee that insurance producers shall be paid for making referrals for affordable health care plans to the Connecticut Connector, as a percentage of the premium;

(5) Establish a subcommittee on healthy lifestyles under section 13 of this act;

(6) Not later than July 1, 2009, establish the Connecticut Health Quality Partnership under section 14 of this act;

(7) Perform the duties as required under section 15 of this act;

(8) Not later than April 1, 2009, develop a plan for (A) the collection of premium from individuals and employers purchasing coverage through the Connecticut Connector, (B) imposition of penalties for late premium payments, as provided in section 38a-483 of the general

statutes, and (C) termination of coverage for nonpayment of premium; and

(9) Not later than January 1, 2010, and annually thereafter, make recommendations to the General Assembly concerning the implementation of the Connecticut Healthy Steps program and improvements to the health care system, including cost controls.

(d) The commission shall meet as often as necessary to complete its work, but not less than quarterly each year. The commission, within available appropriations, may hire consultants and staff, who shall not be hired as employees of the state, to provide assistance with its responsibilities.

(e) For the purposes of sections 2 to 15, inclusive, of this act, "commission" means the Health Care Reform Commission.

Sec. 3. (NEW) (*Effective July 1, 2008*) (a) There is established a program which shall be known as the "Connecticut Connector", to be administered in accordance with the provisions of this section by the Health Reinsurance Association established in section 38a-556 of the general statutes, as amended by this act, and through which eligible individuals and employers may purchase affordable health care plans.

(b) The Health Reinsurance Association shall administer the Connecticut Connector in accordance with the provisions of section 38a-556 of the general statutes, as amended by this act.

(c) Such association administering the Connecticut Connector shall meet with the Health Care Reform Commission appointed in section 2 of this act in accordance with a schedule the commission determines to be appropriate.

(d) The Health Reinsurance Association established pursuant to section 38a-556, as amended by this act, shall perform the following duties:

(1) Screen individual health insurance policy applicants for

eligibility to purchase through the Connecticut Connector;

(2) Screen applicants consisting of individuals for eligibility for the programs established under sections 8 and 9 of this act;

(3) Make payments to agents for referrals of small employers and individuals that qualify for and purchase affordable health care plans;

(4) Collect fees based on total covered lives from all insurers and health care centers licensed in the state to sell health insurance policies or group health insurance plans, excluding the Medicaid managed care health plans, in accordance with rules adopted by the commission, to support the costs of administration as defined by this subsection and any additional functions deemed appropriate by the commission. Covered lives shall include, but not be limited to, all persons who are: (A) Covered under an individual health insurance policy issued or delivered in Connecticut; (B) covered under a group health insurance policy issued or delivered in Connecticut; (C) covered under a group health insurance policy evidenced by a certificate of insurance issued or delivered in Connecticut; or (D) protected in part by a group stop loss insurance policy where the policy or certificate of coverage is issued or delivered in Connecticut and where coverage is purchased by a group health insurance plan subject to the Employee Retirement Income Security Act of 1974, P.L. 93-406, as amended from time to time;

(5) Provide notices as required under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, regarding creditable coverage;

(6) Market the health plans available through the Connecticut Connector to potential purchasers of the health plans including, but not limited to, through the use of advertising, public information campaigns and outreach through the Medicaid and other publicly funded health programs, the chambers of commerce or other trade or professional associations or health care providers;

(7) Provide information to applicants who may be eligible for the Medicaid program or the HUSKY Plan, Part A and Part B, as to how and where to apply for such programs;

(8) Determine employer eligibility for a tax credit and the amount of such tax credit in accordance with section 27 of this act and provide certification for use in claiming such tax credit from the Department of Revenue Services;

(9) Receive moneys from the Comptroller and make payments to eligible individuals and employers in accordance with sections 8 and 9 of this act;

(10) Not later than July 1, 2010, and annually thereafter, provide data and reports to the commission and the General Assembly that shall include, but not be limited to, (A) the number and demographics of previously uninsured persons covered through the Connecticut Connector by type of policy, (B) the per capita administrative costs of the Connecticut Connector, (C) any recommendations for improving service, health insurance policy offerings and costs, and (D) any other information as required by the commission.

(11) For individual insurance: (A) Assisted by the commission, notify insurers of the opportunity to make affordable health care plans available for sale through the Connecticut Connector; (B) assisted by the commission, process applications submitted for individual insurance; (C) publish easy to understand materials for prospective purchasers, comparing the costs and benefits of all plans to assist in plan selection; (D) assist applicants to understand the benefits offered under the plans and assist in selecting a plan that reflects the need and income of the applicant, except that such assistance shall not be deemed to require an insurance agent license; (E) work with the insurers selling products through the Connecticut Connector to develop and adopt a uniform tool approved by the Insurance Commissioner for collecting necessary applicant or enrollee data for any appropriate underwriting, enrollment and other purposes; (F) collect premium contributions from employers and individuals, as well

as subsidies from the state, and remit them to enrollees' health plans; (G) notify insureds when their premiums are late and disenroll them or levy late penalties in accordance with the provisions of section 38a-483 of the general statutes; and (H) provide information regarding Health Reinsurance Association benefits to applicants who are denied coverage due to underwriting concerns;

(12) For small employer plans: (A) Solicit and select two or more third party administrators to administer affordable health care plans; (B) file and obtain Insurance Department approval for affordable health care plans for small employers; (C) perform or contract for all functions necessary to offer and service affordable health care plans, including premium collection, actuarial work to develop rates, issuance of payment to agents, development of application forms, enrollment and obtaining capital for reserves and to cover losses; and (D) price the affordable health care plans to break even each year, with surpluses deposited into a separate, nonlapsing account within the General Fund. The Insurance Commissioner shall use the account to cover future losses or to reduce future premiums, as deemed appropriate by the commission, and losses shall be funded through borrowed funds paid back from future premium increases.

Sec. 4. (NEW) (*Effective March 1, 2010*) (a) The Health Reinsurance Association established pursuant to section 38a-556 of the general statutes, as amended by this act, that administers the Connecticut Connector, as defined in section 3 of this act, shall make available affordable health care plans for individuals and employers established in accordance with standards set forth by the commission.

(b) Such plans shall include: (1) Minimum benefits as follows: (A) Coverage of physician, clinic, ambulatory surgery, laboratory and diagnostic service, in-patient and out-patient hospital care and prescription drugs that are medically necessary, as defined in subsection (a) of section 38a-482a of the 2008 supplement to the general statutes, for physical or mental health; (B) out-of-pocket costs including, but not limited to, copayments, deductibles and coinsurance

that shall reflect the following family income brackets: (i) Family income that is less than two hundred per cent of the federal poverty level, (ii) family income that is equal to or greater than two hundred per cent but less than three hundred per cent of the federal poverty level, (iii) family income that is greater than three hundred per cent but less than four hundred per cent of the federal poverty level, and (iv) family income that is greater than four hundred per cent of the federal poverty level; (C) no deductible for well-child visits, prenatal care and the first two physician visits annually; (D) a lifetime benefits maximum in an amount not less than five hundred thousand dollars, contingent upon availability of an excess cost reinsurance program established by the Department of Social Services as provided in section 18 of this act. In the event such excess cost reinsurance program is not available, the lifetime benefits maximum shall be in an amount not less than one million dollars.

(c) The affordable health care plans shall be exempt from the minimum coverages or benefits set forth in chapter 700c of the general statutes. The premium for such plans shall not exceed two hundred dollars per eligible enrollee or dependent per month on average, adjusted for inflation in average health insurance premiums in the state as determined annually by the Insurance Department. If the Health Reinsurance Association cannot structure an employer plan for this amount or if no carriers are willing to sell a plan for this amount, the commission shall adjust the benefit design.

(d) Individual plans offered for sale through the Connecticut Connector shall be specifically priced to reflect the reduced administrative costs to the insurer resulting from the performance of administrative duties by the Connecticut Connector.

(e) Such individual plans shall have a minimum loss ratio of not less than seventy-five per cent for individual health care plans over any three-year moving average period, provided "loss", for the purposes of such term, shall not include administrative activities including, but not limited to, enrollment, marketing, premium collection, claims

adjudication, member services and profit.

(f) With respect to an applicant for an individual affordable health care plan with an identified preexisting condition, an insurer or health care center offering individual insurance coverage through the Connecticut Connector may: (1) Deny coverage to such applicant; (2) impose an additional deductible of not more than five hundred dollars for such preexisting condition; (3) impose a limitation in accordance with the provisions of section 38a-476 of the 2008 supplement to the general statutes; (4) obtain reinsurance coverage for such identified preexisting condition through the Connecticut Individual Health Reinsurance Pool established under section 6 of this act. The pool reimbursement relative to such preexisting condition shall be limited to the actual paid reinsured benefits in excess of five thousand dollars but not greater than seventy-five thousand dollars for the first twelve months of the term of the individual affordable health care plan reinsured pursuant to this subsection. The board of directors of said pool shall determine the reinsurance premium rates in accordance with the provisions of section 38a-570 of the general statutes. Such amounts shall be annually indexed to the consumer price index for medical care; or (5) impose an exclusionary rider that permanently excludes a narrowly defined condition from coverage.

(g) Each individual affordable health care plan offered through the Connecticut Connector shall: (1) Have premium rates established on the basis of a community rate, adjusted to reflect the individual's age, gender, not more than two levels of health status, excellent and good, family composition, county of residence and tobacco use; and (2) shall be renewable at the option of the policyholder.

(h) The affordable health care plans offered by the Connecticut Connector to small employers shall have premium rates established on the basis of a community rate in accordance with the provisions of subdivision (5) of section 38a-567 of the general statutes, as amended by this act.

(i) Coverage under each of the affordable health care plans shall be

deemed to be creditable coverage, as defined in 42 USC 300gg(c).

(j) Any employer that purchases an affordable health care plan through the Connecticut Connector may offer its employees only that plan or may offer such plan as a choice among an array of comprehensive plans or a high deductible health plan issued with a health savings account. In the event an employer offers plans in addition to the affordable health care plan, such employer may offer the same percentage or dollar contribution for all plans if such employer allows its employees to select a plan.

Sec. 5. (NEW) (*Effective January 1, 2010*) (a) An application by an individual, who can show proof of residency in the state, to purchase coverage through the Connecticut Connector, as defined in section 3 of this act, may be approved in cases in which such individual has no access to employer-sponsored coverage under which the employer pays a minimum of fifty per cent of the cost of such coverage for an individual and his or her dependents and such individual has been either: (1) Uninsured for a period of at least six months; or (2) uninsured for a period of less than six months due to the occurrence of a major life event that has resulted in such uninsured status, including, but not limited to, (A) loss of coverage through the employer, due to termination of employment, (B) death of, or abandonment by, a family member through whom coverage was previously provided, (C) loss of dependent coverage when the individual's spouse became Medicare eligible due to age or disability, (D) loss of coverage as a dependent under any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 of the general statutes due to age, divorce or other changes in status, (E) expiration of the coverage periods established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time, (F) extreme economic hardship on the part of either the employee or the employer, as determined by the organization that administers the Connecticut Connector, in accordance with specific measurable criteria defined by the commission, and (G) any other events that may be specified by the

commission. For purposes of this subsection, "proof of residency" means evidence of domicile in the state such as voter registration, tax filings, utility bill or other documentation deemed satisfactory by the Insurance Commissioner.

(b) An application by an employer to purchase coverage through the Connecticut Connector may be approved if such employer: (1) Has fifty or fewer employees; (2) has not offered a comprehensive health insurance plan to any employee for a period of at least six months; (3) will contribute a minimum of seventy per cent of the cost of the affordable health care plan for an employee or a minimum of fifty per cent of the cost of an employee plus dependent coverage under the least expensive plan available through the Connecticut Connector for any dependent of such employee; and (4) attests to the Health Reinsurance Association that at least ninety per cent of the employer's employees either have coverage through another health care plan or will enroll in a health care plan through the Connecticut Connector.

Sec. 6. (NEW) (*Effective March 1, 2010*) (a) (1) As used in this section:

(A) "Board" means the board of directors of the Connecticut Small Employer Health Reinsurance Pool established under section 38a-569 of the general statutes;

(B) "Commissioner" means the Insurance Commissioner;

(C) "Health care center" means health care center as defined in section 38a-175 of the general statutes;

(D) "Individual" means a natural person provided coverage under an individual health insurance policy that has been approved by the Insurance Department who is deemed to be the policyholder;

(E) "Insurer" means any insurance company, hospital service corporation, medical service corporation or health care center authorized to transact health insurance business in this state;

(F) "Member" means each insurer participating in the pool;

(G) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to subdivision (3) of this subsection;

(H) "Pool" means the Connecticut Individual Health Reinsurance Pool established under subdivision (2) of this subsection.

(2) There is established a nonprofit entity which shall be known as the "Connecticut Individual Health Reinsurance Pool". All insurers issuing health insurance in this state on and after March 1, 2010, shall be members of the pool. The board of directors of the Connecticut Small Employer Health Reinsurance Pool established under section 38a-569 of the general statutes shall administer the pool.

(3) Not later than ninety days after March 1, 2010, the board shall submit to the commissioner a plan of operation and, thereafter, any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The commissioner shall, after notice and hearing, approve the plan of operation, provided the commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis in accordance with the provisions of subsection (d) of this section. The plan of operation shall become effective upon approval, in writing, by the commissioner consistent with the date on which the coverage under this section shall be made available. If the board fails to submit a suitable plan of operation not later than one hundred eighty days after March 1, 2010, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall, after notice and hearing, adopt and promulgate a plan of operation or amendments, as appropriate. The commissioner shall amend any plan adopted, as necessary, at the time a plan of operation is submitted by the board and approved by the commissioner.

(4) The plan of operation shall establish procedures for: (A) Handling and accounting of assets and moneys of the pool, and for an annual fiscal reporting to the commissioner; (B) selecting an

administrator and setting forth the powers and duties of the administrator; (C) reinsuring risks in accordance with the provisions of this section; (D) collecting assessments from all members to provide for claims reinsured by the pool and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made; and (E) any additional matters at the discretion of the board.

(5) The pool shall have the general powers and authority granted under the laws of Connecticut to insurance companies licensed to transact health insurance and, in addition thereto, the specific authority to: (A) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this section, including the authority, with the approval of the commissioner, to enter into contracts with programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions; (B) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of or against members; (C) take such legal action as necessary to avoid the payment of improper claims against the pool; (D) define the array of health coverage products for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this section; (E) establish rules, conditions and procedures pertaining to the reinsurance of members' risks by the pool; (F) establish appropriate rates, rate schedules, rate adjustments, rate classifications and any other actuarial functions appropriate to the operation of the pool; (G) assess members in accordance with the provisions of subsection (e) of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year; (H) appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool; and (I) borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not

in default shall be legal investments for insurers and may be carried as admitted assets.

(b) Any member may reinsure with the pool coverage of an eligible individual, as defined in the pool's plan of operation, who has an identified preexisting condition. The pool reimbursement relative to such preexisting condition shall be limited to the actual paid reinsured benefits in excess of five thousand dollars but not greater than seventy-five thousand dollars for the first twelve months of the term of the individual affordable health care plan reinsured pursuant to this subsection. The board of directors of said pool shall determine the reinsurance premium rated in accordance with the provisions of section 38a-570 of the general statutes. Such amounts shall be annually indexed to the consumer price index for medical care. Any reinsurance placed with the pool from the date of the establishment of the pool regarding such coverage shall be approved by the commissioner. The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the requirements of this section.

(c) Except as provided in subsection (d) of this section, premium rates charged for reinsurance by the pool shall be established by the pool, in accordance with regulations adopted by the commissioner pursuant to chapter 54 of the general statutes.

(d) Premium rates charged for reinsurance by the pool to a health care center licensed pursuant to chapter 698a of the general statutes and subject to requirements that limit the amount of risk that may be ceded to the pool**,** may be modified by the board, if appropriate, to reflect the portion of risk that may be ceded to the pool.

(e) Subject to subsection (c) of this section, (1) following the close of each fiscal year, the administrator shall determine the net premiums, the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by a member that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of

determining assessments. For purposes of this subsection, "net premiums" means health insurance premiums, less administrative expense allowances.

(2) Any net loss for the year shall be recouped by assessments of members as follows:

(A) Assessments shall first be apportioned by the board of directors of such reinsurance pool among all members in proportion to their respective shares of the total health insurance premiums earned in this state from health insurance plans covering individuals during the calendar year coinciding with or ending during the fiscal year of the pool, or on any other equitable basis reflecting coverage of individuals as may be provided in the plan of operations. An assessment shall be made pursuant to this subparagraph against a health care center approved by the Secretary of Health and Human Services as a health maintenance organization pursuant to 42 USC 300e et seq., subject to an assessment adjustment formula adopted by the board and approved by the commissioner for such health care centers, that recognizes the restrictions imposed on such health care centers by federal law. Such adjustment formula shall be adopted by the board and approved by the commissioner prior to the first anniversary of the pool's operation.

(B) If such net loss is not recouped before assessments totaling five per cent of such premiums from plans and arrangements covering eligible individuals have been collected, additional assessments shall be apportioned by the board among all members in proportion to their respective shares of the total health insurance premiums earned in this state from other individual and group plans and arrangements, exclusive of any individual Medicare supplement policies, as defined in section 38a-495 of the general statutes, during such calendar year.

(C) Notwithstanding the provisions of this subdivision, the assessments to any one member under subparagraph (A) or (B) of this subdivision shall not exceed forty per cent of the total assessment under each subparagraph for the first fiscal year of the pool's operation

and fifty per cent of the total assessment under each subparagraph for the second fiscal year. Any amounts abated pursuant to this subparagraph shall be assessed against the other members in a manner consistent with the basis for assessments set forth in this subdivision.

(3) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board of directors of such reinsurance pool to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred, but not reported, claims.

(4) Each member's proportion of participation in the pool shall be determined annually by the said board of directors based on annual statements and other reports deemed necessary by the board and filed by the member with it.

(5) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(6) The said board of directors may defer, in whole or in part, the assessment of a health care center if, in the opinion of the board: (A) Payment of the assessment would endanger the ability of the health care center to fulfill its contractual obligations, or (B) in accordance with standards included in the plan of operation, the health care center has written, and reinsured in their entirety, a disproportionate number of individual health care plans offered under section 4 of this act. In the event an assessment against a health care center is deferred in whole or in part, the amount by which such assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this subsection. The health care center receiving such deferment shall remain liable to the pool for the amount deferred. The board may attach appropriate conditions to any such deferment.

(f) (1) Neither the participation in the pool as members, the establishment of rates, forms or procedures nor any other joint or collective action required by this section shall be the basis of any legal

action, criminal or civil liability or penalty against the pool or any of its members.

(2) Any person or member made a party to any action, suit or proceeding because the person or member served on the board of directors of such reinsurance pool or on a committee or was an officer or employee of the pool shall be held harmless and be indemnified against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit or proceeding. The indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, wilful misfeasance or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all members. The commissioner may retain actuarial consultants necessary to carry out his or her responsibilities pursuant to this section, and such expenses shall be paid by the pool established in this section.

Sec. 7. (NEW) (*Effective October 1, 2008*) (a) The Connecticut Connector, as defined in section 3 of this act, shall, not later than thirty days after receipt of all relevant information provided by an employer, determine whether to certify that an employer is eligible for a tax credit pursuant to section 27 of this act.

(b) The Connecticut Connector shall provide information to employers seeking assistance with obtaining certification pursuant to this section.

Sec. 8. (NEW) (*Effective October 1, 2009*) (a) There is established the health savings account incentive program. To be eligible for payment pursuant to this section, an individual's family income shall not exceed three hundred per cent of the federal poverty level. The Connecticut Connector, as defined in section 3 of this act, shall annually contribute to the health savings account of any individual who has resided in the state for a period of not less than six months and who has a health

savings account and high deductible health plan pursuant to section 223 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, an amount determined by a sliding scale as follows:

(1) For a family income equal to or less than two hundred per cent of the federal poverty level: Five hundred dollars for an individual who has contributed or received contributions of at least two thousand five hundred dollars in his or her health savings account in the previous year; one thousand dollars for a family of two who has contributed or received contributions of at least three thousand seven hundred fifty dollars in their health savings account in the previous year; or one thousand five hundred dollars for a family of three or more who has contributed or received contributions of at least five thousand dollars in their health savings account in the previous year;

(2) For a family income greater than two hundred per cent but less than three hundred per cent of the federal poverty level: Four hundred dollars for an individual who has contributed or received contributions of at least two thousand five hundred dollars in his or her health savings account in the previous year; eight hundred dollars for a family of two who has contributed or received contributions of at least three thousand seven hundred fifty dollars in their health savings account in the previous year; or one thousand two hundred dollars for a family of three or more who has contributed or received contributions of at least five thousand dollars in their health savings account in the previous year.

(b) The amounts specified in subdivisions (1) and (2) of subsection (a) of this section shall be annually indexed to the consumer price index for medical care.

(c) Notwithstanding the provisions of subsection (a) of this section, the Connecticut Connector shall not make contributions to the health savings account of any individual if the total amount in such account exceeds the deductible amount in the high deductible health plan.

(d) The Connecticut Connector shall make payments, in accordance with the provisions of this section, by January thirtieth of any year for health savings account contributions in the prior calendar year. The Health Reinsurance Association shall establish procedures by which individuals may claim payment pursuant to this section.

Sec. 9. (NEW) (*Effective October 1, 2009*) (a) There is established the health insurance premium subsidy program. To be eligible for payment pursuant to this section, an individual (1) shall not have family income greater than three hundred per cent of the federal poverty level, (2) shall not individually or as part of a family own a health savings account pursuant to section 223 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, and (3) shall have an affordable health care plan purchased through the Connecticut Connector, as defined in section 3 of this act, or any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 of the general statutes for which the employee pays at least five hundred dollars in premiums annually to the employee's employer if single and at least one thousand dollars in premiums annually to the employee's employer if the employee is covered by a family plan or under a nonemployer-based plan purchased through the individual market or the Connecticut Connector. The Connecticut Connector shall quarterly reimburse an individual who is eligible pursuant to this section for premiums paid in the preceding quarter an average amount as follows:

(A) For a family with income equal to or less than two hundred per cent of the federal poverty level: Eighty per cent of the individual premium or of their share of the premium for an employer-sponsored plan, not to exceed three hundred dollars per quarter for an individual, six hundred dollars per quarter for an individual plus one dependent or nine hundred dollars per quarter for a family;

(B) For a family with income greater than two hundred per cent but less than three hundred per cent of the federal poverty level: Sixty per

cent of the individual premium or of their share of the premium for an employer-sponsored plan, not to exceed one hundred fifty dollars per quarter for an individual, three hundred dollars per quarter for an individual plus one dependent or four hundred fifty dollars per quarter for a family.

(b) The dollar amounts specified in subparagraphs (A) and (B) of subdivision (3) of subsection (a) of this section shall be adjusted in the case of an individual seeking payment for the purchase of an individual insurance plan based on the age, gender and county of residence of the individual and calculated by the Connecticut Connector to reflect the differences in premiums applied to each rating classification.

(c) The amounts specified in subparagraphs (A) and (B) of subdivision (3) of subsection (a) of this section shall be increased by twenty per cent for any individual purchasing health care coverage through the Health Reinsurance Association.

(d) The Health Reinsurance Association shall establish procedures by which individuals may claim payment pursuant to this section.

Sec. 10. Section 38a-567 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

Health insurance plans and insurance arrangements covering small employers and insurers and producers marketing such plans and arrangements shall be subject to the following provisions:

(1) (A) Any such plan or arrangement shall be renewable with respect to all eligible employees or dependents at the option of the small employer, policyholder or contract-holder, as the case may be, except: (i) For nonpayment of the required premiums by the small employer, policyholder or contract-holder; (ii) for fraud or misrepresentation of the small employer, policyholder or contractholder or, with respect to coverage of individual insured, the insureds or their representatives; (iii) for noncompliance with plan or

arrangement provisions; (iv) when the number of insureds covered under the plan or arrangement is less than the number of insureds or percentage of insureds required by participation requirements under the plan or arrangement; or (v) when the small employer, policyholder or contractholder is no longer actively engaged in the business in which it was engaged on the effective date of the plan or arrangement.

(B) Renewability of coverage may be effected by either continuing in effect a plan or arrangement covering a small employer or by substituting upon renewal for the prior plan or arrangement the plan or arrangement then offered by the carrier that most closely corresponds to the prior plan or arrangement and is available to other small employers. Such substitution shall only be made under conditions approved by the commissioner. A carrier may substitute a plan or arrangement as stated above only if the carrier effects the same substitution upon renewal for all small employers previously covered under the particular plan or arrangement, unless otherwise approved by the commissioner. The substitute plan or arrangement shall be subject to the rating restrictions specified in this section on the same basis as if no substitution had occurred, except for an adjustment based on coverage differences.

(C) Notwithstanding the provisions of this subdivision, any such plan or arrangement, or any coverage provided under such plan or arrangement may be rescinded for fraud, material misrepresentation or concealment by an applicant, employee, dependent or small employer.

(D) Any individual who was not a late enrollee at the time of his or her enrollment and whose coverage is subsequently rescinded shall be allowed to reenroll as of a current date in such plan or arrangement subject to any preexisting condition or other provisions applicable to new enrollees without previous coverage. On and after the effective date of such individual's reenrollment, the small employer carrier may modify the premium rates charged to the small employer for the balance of the current rating period and for future rating periods, to

the level determined by the carrier as applicable under the carrier's established rating practices had full, accurate and timely underwriting information been supplied when such individual initially enrolled in the plan. The increase in premium rates allowed by this provision for the balance of the current rating period shall not exceed twenty-five per cent of the small employer's current premium rates. Any such increase for the balance of said current rating period shall not be subject to the rate limitation specified in subdivision (6) of this section. The rate limitation specified in this section shall otherwise be fully applicable for the current and future rating periods. The modification of premium rates allowed by this subdivision shall cease to be permitted for all plans and arrangements on the first rating period commencing on or after July 1, 1995.

(2) Except in the case of a late enrollee who has failed to provide evidence of insurability satisfactory to the insurer, the plan or arrangement may not exclude any eligible employee or dependent who would otherwise be covered under such plan or arrangement on the basis of an actual or expected health condition of such person. No plan or arrangement may exclude an eligible employee or eligible dependent who, on the day prior to the initial effective date of the plan or arrangement, was covered under the small employer's prior health insurance plan or arrangement pursuant to workers' compensation, continuation of benefits pursuant to federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, **[**(P.L. 99-2721, as amended)**]** P.L. 99-2721, as amended from time to time, or other applicable laws. The employee or dependent must request coverage under the new plan or arrangement on a timely basis and such coverage shall terminate in accordance with the provisions of the applicable law.

(3) (A) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, the premium rates charged or offered for a rating period for all plans and arrangements may not exceed one hundred thirty-five per cent of the base premium rate for all plans or arrangements.

(B) For rating periods commencing on or after July 1, 1994, and prior to July 1, 1995, the premium rates charged or offered for a rating period for all plans or arrangements may not exceed one hundred twenty per cent of the base premium rate for such rating period. The provisions of this subdivision shall not apply to any small employer who employs more than twenty-five eligible employees.

(4) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1995, the percentage increase in the premium rate charged to a small employer, who employs not more than twenty-five eligible employees, for a new rating period may not exceed the sum of:

(A) The percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(B) An adjustment of the small employer's premium rates for the prior rating period, and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer, such adjustment (i) not to exceed ten per cent annually for the rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, and (ii) not to exceed five per cent annually for the rating periods commencing on or after July 1, 1994, and prior to July 1, 1995; and

(C) Any adjustments due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's applicable rate manual.

(5) (A) With respect to plans or arrangements delivered, issued for delivery, renewed, amended or continued in this state on or after **[**July 1, 1995**]** January 1, 2009, the premium rates charged or offered to small employers shall be established on the basis of a community rate, adjusted to reflect one or more of the following classifications:

(i) Age, provided age brackets of less than five years shall not be utilized;

(ii) Gender;

(iii) Geographic area, provided an area smaller than a county shall not be utilized;

(iv) Industry, provided the rate factor associated with any industry classification shall not vary from the arithmetic average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average, and provided further, the rate factors associated with any industry shall not be increased by more than five per cent per year;

(v) Group size, provided the highest rate factor associated with group size shall not vary from the lowest rate factor associated with group size by a ratio of greater than 1.25 to 1.0;

(vi) Administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259, provided the savings reflect a reduction to the small employer carrier's overall retention that is measurable and specifically realized on items such as marketing, billing or claims paying functions taken on directly by the plan administrator or association, except that such savings may not reflect a reduction realized on commissions;

(vii) Savings resulting from a reduction in the profit of a carrier who writes small business plans or arrangements for an association group plan or a plan written pursuant to section 5-259 provided any loss in overall revenue due to a reduction in profit is not shifted to other small employers; **[**and**]**

(viii) Family composition, provided the small employer carrier shall utilize only one or more of the following billing classifications: (I) Employee; (II) employee plus family; (III) employee and spouse; (IV) employee and child; (V) employee plus one dependent; and (VI) employee plus two or more dependents; and

(ix) Participation in a nonsmoking program that complies with the Health Insurance Portability and Accountability Act of 1996, P.L. 104-

191, as amended from time to time.

(B) The small employer carrier shall quote premium rates to small employers after receipt of all demographic rating classifications of the small employer group. No small employer carrier may inquire regarding health status or claims experience of the small employer or its employees or dependents prior to the quoting of a premium rate.

(C) The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued on or after July 1, 1995. The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued prior to July 1, 1995, as of the date of the first rating period commencing on or after that date, but no later than July 1, 1996.

(6) For any small employer plan or arrangement on which the premium rates for employee and dependent coverage or both, vary among employees, such variations shall be based solely on age and other demographic factors permitted under subparagraph (A) of subdivision (5) of this section and such variations may not be based on health status, claim experience, or duration of coverage of specific enrollees. Except as otherwise provided in subdivision (1) of this section, any adjustment in premium rates charged for a small employer plan or arrangement to reflect changes in case characteristics prior to the end of a rating period shall not include any adjustment to reflect the health status, medical history or medical underwriting classification of any new enrollee for whom coverage begins during the rating period.

(7) For rating periods commencing prior to July 1, 1995, in any case where a small employer carrier utilized industry classification as a case characteristic in establishing premium rates, the rate factor associated with any industry classification shall not vary from the arithmetical average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average.

(8) Differences in base premium rates charged for health benefit

plans by a small employer carrier shall be reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

(9) For rating periods commencing prior to July 1, 1995, in any case where an insurer issues or offers a policy or contract under which premium rates for a specific small employer are established or adjusted in part based upon the actual or expected variation in claim costs or actual or expected variation in health conditions of the employees or dependents of such small employer, the insurer shall make reasonable disclosure of such rating practices in solicitation and sales materials utilized with respect to such policy or contract.

(10) If a small employer carrier denies coverage to a small employer, the small employer carrier shall promptly offer the small employer the opportunity to purchase a special health care plan or a small employer health care plan, as appropriate. If a small employer carrier or any producer representing that carrier fails, for any reason, to offer such coverage as requested by a small employer, that small employer carrier shall promptly offer the small employer an opportunity to purchase a special health care plan or a small employer health care plan, as appropriate.

(11) No small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(A) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer, except the provisions of this subparagraph shall not apply to information provided by a small employer carrier or producer to a small employer regarding the carrier's established geographic service area or a restricted network provision of a small employer carrier; or

(B) Encouraging or directing small employers to seek coverage from

another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(12) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic area of the small employer. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a special or a small employer health care plan. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(13) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(14) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reasons for the denial.

(15) No small employer carrier or producer shall disclose (A) to a small employer the fact that any or all of the eligible employees of such small employer have been or will be reinsured with the pool, or (B) to any eligible employee or dependent the fact that he has been or will be reinsured with the pool.

(16) If a small employer carrier enters into a contract, agreement or other arrangement with another party to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the other party shall be subject to the provisions of this section.

(17) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers.

(18) Each small employer carrier shall maintain at its principle place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. Each small employer carrier shall file with the commissioner annually, on or before March fifteenth, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods have been derived using recognized actuarial principles consistent with the provisions of sections 38a-564 to 38a-573, inclusive. Such certification shall be in a form and manner and shall contain such information, as determined by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principle place of business. Any information and documentation described in this subdivision but not subject to the filing requirement shall be made available to the commissioner upon his request. Except in cases of violations of sections 38a-564 to 38a-573, inclusive, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(19) The commissioner may suspend all or any part of this section relating to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(20) For rating periods commencing prior to July 1, 1995, a small employer carrier shall quote premium rates to any small employer within thirty days after receipt by the carrier of such employer's completed application.

(21) Any violation of subdivisions (10) to (16), inclusive, and any regulations established under subdivision (17) of this section shall be an unfair and prohibited practice under sections 38a-815 to 38a-830, inclusive.

(22) With respect to plans or arrangements issued pursuant to subsection (i) of section 5-259, or by an association group plan, at the option of the Comptroller or the administrator of the association group plan, the premium rates charged or offered to small employers purchasing health insurance shall not be subject to this section, provided (A) the plan or plans offered or issued cover such small employers as a single entity and cover not less than ten thousand eligible individuals on the date issued, (B) each small employer is charged or offered the same premium rate with respect to each eligible individual and dependent, and (C) the plan or plans are written on a guaranteed issue basis.

Sec. 11. (NEW) (*Effective July 1, 2008*) The Department of Public Health shall establish and offer incentives for physicians in private practice who provide their services for at least four hours to federally qualified health centers, community health centers, community mental health centers or school-based clinics. Such incentives may include, but not be limited to, reduced cost medical malpractice insurance offered or arranged for by the department and loan forgiveness from postsecondary educational institutions that receive funding from the state and partial payment of educational loans.

Sec. 12. (NEW) (*Effective July 1, 2008*) Not later than January 1, 2009, the Department of Public Health shall expand the Connecticut Tobacco Use Prevention and Control Plan to offer, within available appropriations, smoking cessation medication and supplies, including, but not limited to, nicotine replacement therapy.

Sec. 13. (NEW) (*Effective January 1, 2009*) (a) The Health Care Reform Commission, established under section 2 of this act, shall establish a subcommittee on healthy lifestyles, comprised of six members of said commission, to be selected by the Commissioner of Health Care Access. The subcommittee shall: (1) Not later than March 1, 2010, develop a marketing campaign to educate the public regarding consequences of poor health and basic measures individuals should take to ensure good health; and (2) make recommendations to the General Assembly concerning incentives to encourage personal responsibility in making healthy lifestyle choices.

(b) The subcommittee shall meet at least quarterly each year. The commission, within available appropriations, may hire consultants to provide assistance to the subcommittee with its responsibilities.

(c) The Office of Health Care Access shall, within available appropriations, contract with one or more entities to implement the marketing campaign recommended by the subcommittee on healthy lifestyles.

Sec. 14. (NEW) (*Effective July 1, 2008*) (a) Not later than July 1, 2009, the Health Care Reform Commission, established under section 2 of this act, shall establish the Connecticut Health Quality Partnership. The members of the partnership shall be appointed by the Commissioner of Health Care Access, and shall consist of a minimum of eight representatives from both the private and public sectors, including, but not limited to, health insurers, hospital associations, a representative of physicians, the Commissioners of Public Health and Social Services or their designees, representatives of Medicaid managed care organizations and not more than two consumer advocates who are not otherwise affiliated with any other members. The commission shall assign staff to assist the partnership with its responsibilities.

(b) The Connecticut Health Quality Partnership shall: (1) Be responsible for collecting and analyzing insurance and Medicaid claims data and other data concerning the quality of care and services

provided by health care providers, for the purpose of supporting quality improvement initiatives and enabling consumers to make informed choices with respect to such health care providers; (2) provide comparative data to health care providers concerning the quality of their performance relative to their peers; (3) be responsible for collecting and analyzing data from hospitals pertaining to nosocomial infections for the purpose of tracking, reporting and reducing nosocomial infection rates; (4) be responsible for collecting and analyzing such data from other health care providers, as it deems necessary; (5) be responsible for annually selecting state-wide quality improvement initiatives and encouraging all health plans to adopt such quality improvement initiatives with the same goals and metrics; (6) seek funding from private and federal funding sources; and (7) seek accreditation not later than July 1, 2013, by the National Committee for Quality Assurance as a Quality Plus program.

Sec. 15. (NEW) (*Effective October 1, 2008*) (a) Not later than January 1, 2009, and every five years thereafter, the Office of Health Care Access shall determine the number of residents of this state who are not covered by a health insurance plan. If, by January 1, 2014, the number of uninsured residents has not decreased by fifty per cent from the date of the first determination, the Health Care Reform Commission established by section 2 of this act, shall determine whether it is advisable to require all or certain residents to have health insurance. Not later than January 1, 2015, the commission shall report its findings and recommendations, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance.

(b) Not later than December 31, 2009, and annually thereafter, the Office of Health Care Access shall conduct a survey to determine the number of employers in the state providing health care benefits to employees who reside in this state. Not later than January 1, 2010, and annually thereafter, the office shall submit a report of its findings, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of

matters relating to insurance.

Sec. 16. (*Effective July 1, 2008*) (a) The Commissioner of Public Health shall identify and evaluate current health care programs that provide services to residents of this state who are uninsured.

(b) Not later than September 1, 2009, the Commissioner of Public Health shall submit a report, in accordance with section 11-4a of the general statutes, of findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies. Such report shall identify the programs that are likely to experience a decrease in utilization due to the implementation of the programs and plans established under the Connecticut Healthy Steps program and the amount of such decrease, to the extent feasible.

Sec. 17. (NEW) (*Effective July 1, 2008*) The Office of Health Care Access shall utilize the data obtained pursuant to section 15 of this act relative to any decreases in the number of uninsured residents of this state to make recommendations to the Department of Social Services for commensurate decreases in the disproportionate share payments to hospitals in accordance with the provisions of section 19a-671 of the 2008 supplement to the general statutes.

Sec. 18. (NEW) (*Effective July 1, 2008*) The Commissioner of Social Services shall establish an excess cost reinsurance program to carry out the provisions of subparagraph (D) of subdivision (1) of subsection (b) of section 4 of this act. Such program shall (1) disregard assets equal to the amount of insurance premium payments paid by an insured for an affordable health care plan for the two years prior to Medicaid application, and (2) disregard as income the amount of insurance premium payments made by an insured for an affordable health care plan in the year of Medicaid application. Said commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the requirements of this section.

Sec. 19. (NEW) (*Effective July 1, 2008*) Not later than December 31,

2008, the Commissioner of Social Services shall seek a waiver or waivers of federal Medicaid rules for the purposes of (1) obtaining any available federal reimbursement, including federal financial participation, for state expenditures related to the health savings account incentive program established under section 8 of this act and the premium subsidy program established under section 9 of this act, and (2) establishing a state excess cost reinsurance program for enrollees in the Connecticut Connector's affordable health care plan to allow such enrollees to obtain coverage through the Medicaid program once their insurance benefits are exhausted without having to spend down their assets.

Sec. 20. (NEW) (*Effective July 1, 2008*) (a) The Commissioner of Social Services shall develop a plan to improve the coordination of the delivery of health care services to all or a substantial subset of the aged, blind and disabled Medicaid beneficiaries. Such plan shall include programs to (1) improve coordination of and access to medical services, social services and housing, (2) implement chronic disease management programs, (3) use predictive modeling to identify high risk, complex and high-cost Medicaid beneficiaries, and (4) provide such beneficiaries with intensive clinical care coordination and pharmacological management. The commissioner may contract with an administrative services organization to effectuate the implementation of such plan.

(b) Such plan shall also address: (1) Provider reimbursement systems that are aligned with the goal of managing the care of individuals who have, or are at risk for having, chronic health conditions in order to improve health outcomes and the quality of care for such individuals; and (2) the use and development of outcome measures and reporting requirements, aligned with existing outcome measures within the Department of Social Services, to assess and evaluate the system of chronic care.

(c) Not later than January 1, 2009, the Commissioner of Social Services shall submit such plan, in accordance with section 11-4a of the

general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. On October 1, 2010, and annually thereafter, the Commissioner of Social Services shall report, in accordance with the provisions of section 11-4a of the general statutes, on the status of implementation of such plan to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. The report shall include the number of individuals and health care providers participating in the programs specified in subsection (a) of this section, indicators of quality improvement and patient satisfaction, annual expenditures and savings associated with the plan and such other information as may be requested by said joint standing committees.

Sec. 21. (NEW) (*Effective July 1, 2008*) On and after January 1, 2009, the Commissioner of Social Services shall allow aged, blind or disabled Medicaid beneficiaries to voluntarily enroll in the managed care plans available to HUSKY Plan, Part A and HUSKY Plan, Part B beneficiaries.

Sec. 22. Subsection (a) of section 17b-192 of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2008*):

(a) The Commissioner of Social Services shall implement a state medical assistance component of the state-administered general assistance program for persons ineligible for Medicaid. Eligibility criteria concerning income shall be the same as the medically needy component of the Medicaid program <u>as utilized on June 30, 2008</u>, except that earned monthly gross income of up to one hundred fifty dollars shall be disregarded. Unearned income shall not be disregarded. No person who has family assets exceeding one thousand dollars shall be eligible. No person shall be eligible for assistance under this section if such person made, during the three months prior to the month of application, an assignment or transfer or other

disposition of property for less than fair market value. The number of months of ineligibility due to such disposition shall be determined by dividing the fair market value of such property, less any consideration received in exchange for its disposition, by five hundred dollars. Such period of ineligibility shall commence in the month in which the person is otherwise eligible for benefits. Any assignment, transfer or other disposition of property, on the part of the transferor, shall be presumed to have been made for the purpose of establishing eligibility for benefits or services unless such person provides convincing evidence to establish that the transaction was exclusively for some other purpose.

Sec. 23. Section 17b-261 of the 2008 supplement to the general statutes is amended by adding subsections (j) and (k) as follows (*Effective July 1, 2008*):

(NEW) (j) Notwithstanding the provisions of this section, the Commissioner of Social Services, pursuant to 42 USC 1396a(r)(2), shall file an amendment to the Medicaid state plan that allows said commissioner, when making Medicaid income eligibility determinations, to establish a special income disregard applicable only to the Medicaid program that permits individuals who are aged, blind or disabled and who have income that is not greater than one hundred per cent of the federal poverty level to qualify for Medicaid.

(NEW) (k) To the extent permitted by federal law, the Commissioner of Social Services may impose copayments on persons eligible for medical assistance under the provisions of this section who utilize the emergency room of a hospital to access services of a nonemergency nature. Services of a nonemergency nature shall be defined by the commissioner after consultation with representative staff of emergency rooms throughout the state. Prior to imposing any such copayments, the commissioner shall provide not less than thirty days written notice to all persons eligible for medical assistance under this section advising such persons of the impending implementation of copayments and the Department of Social Services' policies that will be

applicable to such copayments. The first instance of emergency room use by an eligible person to access services of a nonemergency nature shall not result in the imposition of a copayment, but the staff at such emergency room shall provide verbal and written notice, in a manner prescribed by the commissioner, that advises such person that continued use of the emergency room for services of a nonemergency nature shall result in the imposition of copayments on the recipient and that such person should seek nonemergency care from other providers assigned to provide medical assistance to such person in accordance with the provisions of this section. Any copayment imposed pursuant to this subsection shall not exceed the sum of twenty-five dollars per visit and the hospital shall have the discretion to waive collection of the copayment based on a determination of hardship or otherwise. The commissioner shall not deduct any copayment imposed pursuant to this subsection from payments that are due and owing from the department to such emergency room.

Sec. 24. Section 17b-292 of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2008*):

(a) A child who resides in a household with a family income which exceeds one hundred eighty-five per cent of the federal poverty level and does not exceed three hundred per cent of the federal poverty level may be eligible for subsidized benefits under the HUSKY Plan, Part B.

(b) A child who resides in a household with a family income over three hundred per cent of the federal poverty level may be eligible for unsubsidized benefits under the HUSKY Plan, Part B.

(c) Whenever a court or family support magistrate orders a noncustodial parent to provide health insurance for a child, such parent may provide for coverage under the HUSKY Plan, Part B.

(d) On and after January 1, 2009, a child who is determined to be eligible for benefits under either the HUSKY Plan, Part A or Part B,

shall remain eligible for such plan for a period of twelve months from such child's determination of eligibility unless the child attains the age of nineteen or is no longer a resident of the state. An adult who is determined to be eligible for benefits under the HUSKY Plan, Part A shall, unless otherwise precluded under federal law, remain eligible for such plan for a period of twelve months from such adult's determination of eligibility unless the adult is no longer a resident of the state. During the twelve-month period following the date that an adult or child is determined eligible for the HUSKY Plan, Part A or Part B, the adult or family of such child shall comply with federal requirements concerning the reporting of information to the department, including, but not limited to, change of address information.

[(d)**]** (e) To the extent allowed under federal law, the commissioner shall not pay for services or durable medical equipment under the HUSKY Plan, Part B if the enrollee has other insurance coverage for the services or such equipment.

[(e)**]** (f) A newborn child who otherwise meets the eligibility criteria for the HUSKY Plan, Part B shall be eligible for benefits retroactive to his or her date of birth, provided an application is filed on behalf of the child not later than thirty days after such date. Any uninsured child born in a hospital in this state or in a border state hospital shall be enrolled on an expedited basis in the HUSKY Plan, Part B, provided (1) the parent or caretaker relative of such child resides in this state, and (2) the parent or caretaker relative of such child authorizes enrollment in the program. The commissioner shall pay any premium cost such family would otherwise incur for the first four months of coverage to the managed care organization selected by the parent or caretaker relative to provide coverage for such child.

[(f)**]** (g) The commissioner shall implement presumptive eligibility for children applying for Medicaid. Such presumptive eligibility determinations shall be in accordance with applicable federal law and regulations. The commissioner shall adopt regulations, in accordance

with chapter 54, to establish standards and procedures for the designation of organizations as qualified entities to grant presumptive eligibility. Qualified entities shall ensure that, at the time a presumptive eligibility determination is made, a completed application for Medicaid is submitted to the department for a full eligibility determination. In establishing such standards and procedures, the commissioner shall ensure the representation of state-wide and local organizations that provide services to children of all ages in each region of the state.

[(g)**]** (h) The commissioner shall provide for a single point of entry servicer for applicants and enrollees under the HUSKY Plan, Part A and Part B. The commissioner, in consultation with the servicer, shall establish a centralized unit to be responsible for processing all applications for assistance under the HUSKY Plan, Part A and Part B. The department, through its servicer, shall ensure that a child who is determined to be eligible for benefits under the HUSKY Plan, Part A, or the HUSKY Plan, Part B has uninterrupted health insurance coverage for as long as the parent or guardian elects to enroll or re-enroll such child in the HUSKY Plan, Part A or Part B. The commissioner, in consultation with the servicer, and in accordance with the provisions of section 17b-297 of the 2008 supplement to the general statutes, shall jointly market both Part A and Part B together as the HUSKY Plan and shall develop and implement public information and outreach activities with community programs. Such servicer shall electronically transmit data with respect to enrollment and disenrollment in the HUSKY Plan, Part A and Part B to the commissioner.

[(h)**]** (i) Upon the expiration of any contractual provisions entered into pursuant to subsection **[**(g)**]** (h) of this section, the commissioner shall develop a new contract for single point of entry services and managed care enrollment brokerage services. The commissioner may enter into one or more contractual arrangements for such services for a contract period not to exceed seven years. Such contracts shall include performance measures, including, but not limited to, specified time

limits for the processing of applications, parameters setting forth the requirements for a completed and reviewable application and the percentage of applications forwarded to the department in a complete and timely fashion. Such contracts shall also include a process for identifying and correcting noncompliance with established performance measures, including sanctions applicable for instances of continued noncompliance with performance measures.

[(i)**]** (j) The single point of entry servicer shall send all applications and supporting documents to the commissioner for determination of eligibility. The servicer shall enroll eligible beneficiaries in the applicant's choice of managed care plan. Upon enrollment in a managed care plan, an eligible HUSKY Plan Part A or Part B beneficiary shall remain enrolled in such managed care plan for twelve months from the date of such enrollment unless (1) an eligible beneficiary demonstrates good cause to the satisfaction of the commissioner of the need to enroll in a different managed care plan, or (2) the beneficiary no longer meets program eligibility requirements.

[(j)**]** (k) Not later than ten months after the determination of eligibility for benefits under the HUSKY Plan, Part A and Part B and annually thereafter, the commissioner or the servicer, as the case may be, shall within existing budgetary resources, mail or, upon request of a participant, electronically transmit an application form to each participant in the plan for the purposes of obtaining information to make a determination on continued eligibility beyond the twelve months of initial eligibility. To the extent permitted by federal law, in determining eligibility for benefits under the HUSKY Plan, Part A or Part B with respect to family income, the commissioner or the servicer shall rely upon information provided in such form by the participant unless the commissioner or the servicer has reason to believe that such information is inaccurate or incomplete. The Department of Social Services shall annually review a random sample of cases to confirm that, based on the statistical sample, relying on such information is not resulting in ineligible clients receiving benefits under HUSKY Plan Part A or Part B. The determination of eligibility shall be coordinated

with health plan open enrollment periods.

[(k)**]** (l) The commissioner shall implement the HUSKY Plan, Part B while in the process of adopting necessary policies and procedures in regulation form in accordance with the provisions of section 17b-10.

[(l)**]** (m) The commissioner shall adopt regulations, in accordance with chapter 54, to establish residency requirements and income eligibility for participation in the HUSKY Plan, Part B and procedures for a simplified mail-in application process. Notwithstanding the provisions of section 17b-257b, such regulations shall provide that any child adopted from another country by an individual who is a citizen of the United States and a resident of this state shall be eligible for benefits under the HUSKY Plan, Part B upon arrival in this state.

Sec. 25. Section 17b-267 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

(a) If any group or association of providers of medical assistance services wishes to have payments as provided for under sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to 17b-361, inclusive, to such providers made through a national, state or other public or private agency or organization and nominates such agency or organization for this purpose, the Commissioner of Social Services is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization, subject to such review by the Commissioner of Social Services as may be provided for by the agreement, of the payments required to be made to such providers at the rates set by the hospital cost commission, and for the making of such payments by such agency or organization to such providers. Such agreement may also include provision for the agency or organization to do all or any part of the following: With respect to the providers of services which are to receive payments through it, (1) to serve as a center for, and to communicate to providers, any information or instructions furnished to it by the Commissioner of Social Services, and to serve as a channel of communication from providers to the Commissioner of Social

Services; (2) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this section; and (3) to perform such other functions as are necessary to carry out the provisions of sections 17b-267 to 17b-271, inclusive, as amended by this act.

(b) The Commissioner of Social Services shall not enter into an agreement with any agency or organization under subsection (a) of this section unless (1) he finds (A) that to do so is consistent with the effective and efficient administration of the medical assistance program, and (B) that such agency or organization is willing and able to assist the providers to which payments are made through it in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 17b-261 of the 2008 supplement to the general statutes, as amended by this act, and the agreement provides for such assistance, and (2) such agency or organization agrees to furnish to the Commissioner of Social Services such of the information acquired by it in carrying out its agreement under sections 17b-267 to 17b-271, inclusive, as amended by this act, as the Commissioner of Social Services may find necessary in performing his functions under said sections.

(c) An agreement with any agency or organization under subsection (a) of this section may contain such terms and conditions as the Commissioner of Social Services finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under said subsection (a), and shall provide for payment by the Commissioner of Social Services of so much of the cost of administration of the agency or organization as is determined by the Commissioner of Social Services to be necessary and proper for carrying out the functions covered by the agreement.

(d) Each managed care plan that enters into, renews or amends a contract with the Department of Social Services pursuant to this section shall limit its administrative costs to ten per cent of payments

made pursuant to such contracts. The Commissioner of Social Services shall implement policies and procedures to effectuate the purpose of this subsection while in the process of adopting such policies or procedures in regulation form, provided notice of intention to adopt the regulations is printed in the Connecticut Law Journal not later than twenty days after implementation and any such policies and procedures shall be valid until the time the regulations are effective. The Commissioner of Social Services may define administrative costs to exclude disease management or other value-added clinical programs administered by the managed care plans, but not to exclude utilization management, claims, member services or other nonclinical functions.

Sec. 26. (NEW) (*Effective July 1, 2008*) To the extent permitted by federal law, any employer in the state that offers health care benefits to its employees shall offer benefits or premium contributions that are equivalent in value to all such employees regardless of any differential in the amount of compensation paid to such employees. Nothing in this section shall preclude an employer from offering employees with a lower amount of compensation a more comprehensive health care benefit plan or a higher level of employer premium contribution than offered to employees receiving a higher amount of compensation.

Sec. 27. (NEW) (*Effective January 1, 2010, and applicable to income years commencing on or after January 1, 2010*) (a) For purposes of this section:

(1) "Employer" means any person, firm, business, educational institution, nonprofit agency, corporation, limited liability company or any other business entity which, on at least fifty per cent of its working days during the preceding twelve months, (A) employed ten or fewer employees, (B) employed eleven to fifty employees, of whom at least thirty per cent were paid annualized wages by the employer equal to or less than three hundred per cent of the federal poverty level for a family of three, or (C) employed more than fifty employees, at least seventy-five per cent of whom were paid annualized wages by the employer equal to or less than one hundred eighty-five per cent of the

federal poverty level for a family of three;

(2) "Full-time employee" means any person employed in or residing in this state, who is not a temporary or seasonal employee, employed by an employer and required to work a minimum of thirty-five hours per week; and

(3) "Part-time employee" means any person employed in or residing in this state, who is not a temporary or seasonal employee, employed by an employer and required to work less than thirty-five hours per week.

(b) (1) There is established a tax credit program to assist employers with providing health insurance to their employees to achieve the goal of ensuring greater access to health insurance for residents of this state. Any employer that elects to claim a tax credit pursuant to this section shall submit to the Connecticut Connector, as established in section 3 of this act, a copy of such employer's health insurance plan, documentation of employees' wages and proof of such employer's premium contributions. If the Connecticut Connector certifies that such plan meets or exceeds the type and level of benefits of the Affordable Health Care Plans established pursuant to section 2 of this act, the Connecticut Connector shall issue a certificate indicating such fact.

(2) To qualify for a tax credit pursuant to this section, an employer shall (A) obtain a certificate from the Connecticut Connector in accordance with this section, and (B) pay a minimum of seventy per cent of the cost of an employee's health care benefits or a minimum of fifty per cent of the cost of an employee plus dependents' health care benefits for full-time employees.

(c) An employer shall be allowed a tax credit against the tax imposed under chapter 208 of the general statutes for income years commencing on or after January 1, 2010, in the following amounts:

(1) For employers offering such coverage to all full-time employees

but not part-time employees, the credit shall be in an amount equal to twenty per cent of the cost of providing health care benefits, provided such amount shall not exceed eight hundred dollars per employee per year in the case of a policy covering an individual employee, one thousand six hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or two thousand four hundred dollars per employee per year in the case of a policy covering an employee and the family of such employee;

(2) For employers offering such coverage to all full-time and part-time employees, the credit shall be in an amount equal to thirty per cent of the cost of providing health care benefits, provided such amount shall not exceed one thousand two hundred dollars per employee per year in the case of a policy covering an individual employee, two thousand four hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or three thousand six hundred dollars per employee per year in the case of a policy covering an employee and the family of such employee.

(d) An employer qualifying under subsection (b) of this section that is a limited liability company, limited liability partnership, limited partnership or S corporation, as defined in section 12-284b of the general statutes, may distribute a credit to its members and such members shall be eligible to use such credit against the tax imposed under chapter 229 of the general statutes. The total credit that may be distributed shall not be greater than the following:

(1) For employers offering such coverage to all full-time employees but not part-time employees, the credit shall be in an amount equal to twenty per cent of the cost of providing health benefits, provided such amount shall not exceed eight hundred dollars per employee per year in the case of a policy covering an individual employee, one thousand six hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or two thousand four hundred dollars per employee per year in the case of a policy

covering the employee and the family of such employee;

(2) For employers offering such coverage to all full-time and part-time employees, the credit shall be in an amount equal to thirty per cent of the cost of providing health benefits, provided such amount shall not exceed one thousand two hundred dollars per employee per year in the case of a policy covering an individual employee, two thousand four hundred dollars per employee per year in the case of a policy covering an employee and only one other individual, or three thousand six hundred dollars per employee per year in the case of a policy covering an employee and the family of such employee.

(e) (1) In the event the employer owes less than the value of the credit allowed under subsection (c) of this section, the employer shall be entitled to a refund from the state in an amount equal to the amount of the unused credit.

(2) In the event the individual claiming a credit under subsection (d) of this section owes less than the value of the credit allowed under said subsection, the individual shall be entitled to a refund from the state in an amount equal to the amount of the unused credit.

(f) The dollar amount of the credits in subsections (c) and (d) of this section shall be annually indexed to the consumer price index for medical care.

Sec. 28. Section 38a-556 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2008*):

There is hereby created a nonprofit legal entity to be known as the Health Reinsurance Association. All insurers, health care centers and self-insurers doing business in the state, as a condition to their authority to transact the applicable kinds of health insurance defined in section 38a-551 and under sections 3 and 4 of this act, shall be members of the association. The association shall perform its functions under a plan of operation established and approved under subdivision (a) of this section, and shall exercise its powers through a board of

directors established under this section.

(a) (1) The board of directors of the association shall be made up of nine individuals selected by participating members, subject to approval by the commissioner, two of whom shall be appointed by the commissioner on or before July 1, 1993, to represent health care centers. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the net health insurance premium derived from this state in the previous calendar year. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. (2) The board shall submit to the commissioner a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under sections 38a-505, 38a-546, **[**and**]** 38a-551 to 38a-559, inclusive, and under sections 3 and 4 of this act, must be made available. The commissioner shall, after notice and hearing, approve the plan of operation provided such plan is determined to be suitable to assure the fair, reasonable and equitable administration of the association, and provides for the sharing of association gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or if at any time thereafter the board fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this

section. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall, in addition to requirements enumerated in sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive: (A) Establish procedures for the handling and accounting of assets and moneys of the association; (B) establish regular times and places for meetings of the board of directors; (C) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner; (D) establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner; (E) establish procedures to amend, subject to the approval of the commissioner, the plan of operations; (F) establish procedures for the selection of an administering carrier and set forth the powers and duties of the administering carrier; (G) contain additional provisions necessary or proper for the execution of the powers and duties of the association; (H) establish procedures for the advertisement on behalf of all participating carriers of the general availability of the comprehensive coverage under sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive; (I) contain additional provisions necessary for the association to qualify as an acceptable alternative mechanism in accordance with Section 2744 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996, **[**(P.L. 104-191)**]** P.L. 104-191, as amended from time to time; and (J) contain additional provisions necessary for the association to qualify as acceptable coverage in accordance with the Pension Benefit Guaranty Corporation and Trade Adjustment Assistance programs of the Trade Act of 2002, **[**(P.L. 107-210)**]** P.L. 107-210, as amended from time to time. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to establish criteria for the association to qualify as an acceptable alternative mechanism.

(b) The association shall have the general powers and authority granted under the laws of this state to carriers to transact the kinds of insurance defined under section 38a-551, and in addition thereto, the specific authority to: (1) Enter into contracts necessary or proper to

carry out the provisions and purposes of sections 38a-505, 38a-546, [and] 38a-551 to 38a-559, inclusive, and under sections 3 and 4 of this act; (2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating members; (3) take such legal action as necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association; (4) establish, with respect to health insurance provided by or on behalf of the association, appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the operational expenses of the association; (5) administer any type of reinsurance program, for or on behalf of participating members; (6) pool risks among participating members; (7) issue policies of insurance on an indemnity or provision of service basis providing the coverage required by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, in its own name or on behalf of participating members; (8) administer separate pools, separate accounts or other plans as deemed appropriate for separate members or groups of members; (9) operate and administer any combination of plans, pools, reinsurance arrangements or other mechanisms as deemed appropriate to best accomplish the fair and equitable operation of the association; (10) set limits on the amounts of reinsurance which may be ceded to the association by its members; (11) appoint from among participating members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association; and (12) apply for and accept grants, gifts and bequests of funds from other states, federal and interstate agencies and independent authorities, private firms, individuals and foundations for the purpose of carrying out its responsibilities. Any such funds received shall be deposited in the General Fund and shall be credited to a separate nonlapsing account within the General Fund for the Health Reinsurance Association and may be used by the Health Reinsurance Association in the performance of its duties.

(c) Every member shall participate in the association in accordance with the provisions of this subdivision. (1) A participating member shall determine the particular risks it elects to have written by or through the association. A member shall designate which of the following classes of risks it shall underwrite in the state, from which classes of risk it may elect to reinsure selected risks: (A) Individual, excluding group conversion; and (B) individual, including group conversion. (2) No member shall be permitted to select out individual lives from an employer group to be insured by or through the association. Members electing to administer risks which are insured by or through the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk insured by or through the association cannot be withdrawn by the participating member except in accordance with the rules established by the association. (3) Rates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. Separate scales of premium rates based on age shall apply, but rates shall not be adjusted for area variations in provider costs. Premium rates shall take into consideration the substantial extra morbidity and administrative expenses for association risks, reimbursement or reasonable expenses incurred for the writing of association risks and the level of rates charged by insurers for groups of ten lives, provided incurred losses which result from provision of coverage in accordance with section 38a-537 shall not be considered. In no event shall the rate for a given classification or group be less than one hundred twenty-five per cent or more than one hundred fifty per cent of the average rate charged for that classification with similar characteristics under a policy covering ten lives. All rates shall be promulgated by the association through an actuarial committee consisting of five persons who are members of the American Academy of Actuaries, shall be filed with the commissioner and may be disapproved within sixty days from the filing thereof if excessive, inadequate or unfairly discriminatory.

(d) (1) Following the close of each fiscal year, the administering carrier shall determine the net premiums, reinsurance premiums less

administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses for the year. Any net loss shall be assessed to all participating members in proportion to their respective shares of the total health insurance premiums earned in this state during the calendar year, or with paid losses in the year, coinciding with or ending during the fiscal year of the association or on any other equitable basis as may be provided in the plan of operations. For self-insured members of the association, health insurance premiums earned shall be established by dividing the amount of paid health losses for the applicable period by eighty-five per cent. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums. (2) Any net loss to the association represented by the excess of its actual expenses of administering policies issued by the association over the applicable expense allowance shall be separately assessed to those participating members who do not elect to administer their plans. All assessments shall be on an equitable formula established by the board. (3) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association and the association shall have an annual audit of its operations by an independent certified public accountant. The annual audit shall be filed with the commissioner for his review and the association shall be subject to the provisions of section 38a-14. (4) For the fiscal year ending December 31, 1993, and the first quarter of the fiscal year ending December 31, 1994, the administering carrier shall not include health care centers in assessing any net losses to participating members.

(e) All policy forms issued by or through the association shall conform in substance to prototype forms developed by the association, shall in all other respects conform to the requirements of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, and shall be approved by the commissioner. The commissioner may disapprove any such form if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy.

(f) Unless otherwise permitted by the plan of operation, the association shall not issue, reissue or continue in force comprehensive health care plan coverage with respect to any person who is already covered under an individual or group comprehensive health care plan, or who is sixty-five years of age or older and eligible for Medicare or who is not a resident of this state. Coverage provided to a HIPAA or health care tax credit eligible individual may be terminated to the extent permitted by **[**HIPAA**]** the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, or the Trade Act of 2002, P.L. 107-210, as amended from time to time, respectively.

(g) Benefits payable under a comprehensive health care plan insured by or reinsured through the association shall be paid net of all other health insurance benefits paid or payable through any other source, and net of all health insurance coverages provided by or pursuant to any other state or federal law including Title XVIII of the Social Security Act, Medicare, but excluding Medicaid.

(h) There shall be no liability on the part of and no cause of action of any nature shall arise against any carrier or its agents or its employees, the Health Reinsurance Association or its agents or its employees or the residual market mechanism established under the provisions of section 38a-557 or its agents or its employees, or the commissioner or his representatives for any action taken by them in the performance of their duties under sections 38a-505, 38a-546**,** **[**and**]** 38a-551 to 38a-559, inclusive, and under sections 3 and 4 of this act. This provision shall not apply to the obligations of a carrier, a self-insurer, the Health Reinsurance Association or the residual market mechanism for payment of benefits provided under a comprehensive health care plan.

Sec. 29. (*Effective July 1, 2008*) Notwithstanding the provisions of section 4-28e of the general statutes, the sum remaining in the Tobacco and Health Trust Fund shall be transferred from said fund to the General Fund, of which twenty million dollars shall be used by the Department of Public Health for the Connecticut Tobacco Use

Prevention and Control Plan.

Sec. 30. (*Effective July 1, 2008*) The sum of one million dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2009, to expand the Connecticut Tobacco Use Prevention and Control Plan to cover smoking cessation medication and supplies, including, but not limited to, nicotine replacement therapy.

Sec. 31. (*Effective July 1, 2008*) The sum of one million six hundred thousand dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2009, for the purpose of providing grants to be awarded on July 1, 2009, in the amount of two hundred thousand dollars to eight different groups representing the interests of Connecticut employers. The Commissioner of Public Health, in accordance with the provisions of chapter 54 of the general statutes, shall establish the criteria and procedures used to select said groups. Such grants shall be used to train employers to effectively educate employees concerning the financial and health benefits of making lifestyle choices that promote good health, including maintaining a healthy weight and regular exercise.

Sec. 32. (*Effective July 1, 2008*) The sum of one million dollars is appropriated to the Department of Social Services, from the General Fund, for the fiscal year ending June 30, 2009, for the purpose of obtaining consultant services to assist said department in the implementation of section 19 of this act.

Sec. 33. (*Effective July 1, 2008*) The sum of ____ dollars is appropriated to the Office of Health Care Access, from the General Fund, for the fiscal year ending June 30, 2009, for the purposes of section 8 of this act.

Sec. 34. (*Effective July 1, 2008*) The sum of ____ dollars is appropriated to the Office of Health Care Access, from the General Fund, for the fiscal year ending June 30, 2009, for the purposes of

section 9 of this act.

Sec. 35. (*Effective July 1, 2008*) The sum of five hundred thousand dollars is appropriated to the Office of Health Care Access, from the General Fund, for the fiscal year ending June 30, 2009, for the purposes of the Health Care Reform Commission established under section 2 of this act.

Sec. 36. (*Effective July 1, 2008*) The sum of five hundred thousand dollars is appropriated to the Office of Health Care Access, from the General Fund, for the fiscal year ending June 30, 2009, for the purpose of providing one-time start-up funds for the establishment of the Connecticut Health Quality Partnership pursuant to section 14 of this act, which shall be contingent upon the partnership obtaining a commitment by six or more members to contribute dues sufficient to assure the financial viability of the organization.

Sec. 37. (*Effective July 1, 2008*) The sum of two hundred thousand dollars is appropriated to the Office of Health Care Access, from the General Fund, for the fiscal year ending June 30, 2009, for the purpose of conducting the study and survey as required by section 15 of this act.

Sec. 38. (*Effective July 1, 2008*) The sum of two hundred fifty thousand dollars is appropriated to the Office of Health Care Access, from the General Fund, for the fiscal year ending June 30, 2009, for the purposes of the subcommittee on healthy lifestyles established under section 13 of this act.

Sec. 39. (*Effective July 1, 2009*) The sum of two hundred sixty thousand dollars is appropriated to the Office of Health Care Access, from the General Fund, for the fiscal year ending June 30, 2010, for the purposes of the subcommittee on healthy lifestyles established under section 13 of this act.

Sec. 40. (*Effective July 1, 2008*) The sum of one million dollars is appropriated to the Insurance Department, from the General Fund, for

the fiscal year ending June 30, 2009, for the purpose of providing start-up costs for the Connecticut Connector including, but not limited to, web site development, a premium subsidy administration system, marketing, communications, administrative functions, and purchase of other technology and equipment to facilitate and streamline operation and administration of the Connecticut Connector.

Sec. 41. (*Effective July 1, 2008*) (a) The sum of one million five hundred thousand dollars is appropriated to the Insurance Department, from the General Fund, for the fiscal year ending June 30, 2009, to operate and administer the Connecticut Connector, and to market the affordable health care plans.

(b) The sum of one million dollars is appropriated to the Insurance Department, from the General Fund, for the fiscal year ending June 30, 2010, to operate and administer the Connecticut Connector, and to market the affordable health care plans.

Sec. 42. (*Effective January 1, 2009*) Section 17b-261c of the general statutes is repealed.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2008*	New section
Sec. 2	*July 1, 2008*	New section
Sec. 3	*July 1, 2008*	New section
Sec. 4	*March 1, 2010*	New section
Sec. 5	*January 1, 2010*	New section
Sec. 6	*March 1, 2010*	New section
Sec. 7	*October 1, 2008*	New section
Sec. 8	*October 1, 2009*	New section
Sec. 9	*October 1, 2009*	New section
Sec. 10	*January 1, 2009*	38a-567
Sec. 11	*July 1, 2008*	New section
Sec. 12	*July 1, 2008*	New section
Sec. 13	*January 1, 2009*	New section
Sec. 14	*July 1, 2008*	New section
Sec. 15	*October 1, 2008*	New section

Sec. 16	*July 1, 2008*	New section
Sec. 17	*July 1, 2008*	New section
Sec. 18	*July 1, 2008*	New section
Sec. 19	*July 1, 2008*	New section
Sec. 20	*July 1, 2008*	New section
Sec. 21	*July 1, 2008*	New section
Sec. 22	*July 1, 2008*	17b-192(a)
Sec. 23	*July 1, 2008*	17b-261
Sec. 24	*July 1, 2008*	17b-292
Sec. 25	*July 1, 2009*	17b-267
Sec. 26	*July 1, 2008*	New section
Sec. 27	*January 1, 2010, and applicable to income years commencing on or after January 1, 2010*	New section
Sec. 28	*July 1, 2008*	38a-556
Sec. 29	*July 1, 2008*	New section
Sec. 30	*July 1, 2008*	New section
Sec. 31	*July 1, 2008*	New section
Sec. 32	*July 1, 2008*	New section
Sec. 33	*July 1, 2008*	New section
Sec. 34	*July 1, 2008*	New section
Sec. 35	*July 1, 2008*	New section
Sec. 36	*July 1, 2008*	New section
Sec. 37	*July 1, 2008*	New section
Sec. 38	*July 1, 2008*	New section
Sec. 39	*July 1, 2009*	New section
Sec. 40	*July 1, 2008*	New section
Sec. 41	*July 1, 2008*	New section
Sec. 42	*January 1, 2009*	Repealer section

Statement of Legislative Commissioners:
Technical changes were made for accuracy and clarity. In section 27, the redundant phrase "employed in or residing in this state" in (c) and (d) was removed.

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact: See Below

Municipal Impact: None

Explanation

This bill makes various changes to the health care system in Connecticut, as detailed below.

Section 2 establishes a fourteen member Health Care Reform Commission, and places it within the Office of Health Care Access (OHCA) for administrative purposes only. As members are entitled to reimbursement for expenses, associated minimal costs will be incurred by the Office.

Costs of consultant services needed to assist the Commission cannot be determined in advance. However, they would be anticipated to be significant in magnitude. **Section 35** appropriates $500,000 to OHCA to carry out the provisions of section 2.

Should no appropriation be included within the enacted FY 09 Biennial Budget Adjustment for consultant services, the requirement that associated costs be accommodated within available appropriations will likely result in one of four outcomes: (1) The Commission will proceed, and OHCA will require a deficiency appropriation; (2) the Commission will delay implementation pending the approval of additional appropriations in future fiscal years to OHCA; (3) OHCA will shift resources from other departmental priorities, thereby impacting existing departmental programs; or (4) the Commission will be unable to proceed.

It should be noted that administrative services are currently

provided to OHCA by the Department of Administrative Services (DAS). Therefore, a workload increase will be experienced by DAS to the extent that additional services are required.

It is anticipated that the Commissioners of Social Services, Health Care Access, and Insurance, or their designees, will participate in the activities of the Commission within each agency's normally budgeted resources.

Section 3 establishes the Connecticut Connector under the Health Reinsurance Association (HRA) in the Department of Insurance (DOI). **Section 40** of the bill appropriates $1,000,000 in FY09 to DOI for the costs incurred in starting the Connector. **Section 41** appropriates $1,500,000 in FY09 and $1,000,000 in FY10 to DOI to operate and administer the Connector.

The Connector will serve as a health insurance purchasing pool, through which previously uninsured individuals, and employers who previously did not offer health insurance, may purchase health plans. HRA must solicit insurers to sell products through the Connector, review and publicize plan benefits and costs, and screen applicants, among other duties. The bill allows HRA to collect fees from all insurers and health care centers in the state to administer this program. It thus appears that beyond the funds provided in Sections 40 and 41, the state would not incur any direct costs from the operation of the Connector.

Sections 4 and 5 of the bill specify what types of health plans will be provided under the Connector as well as which individuals and employers will be eligible to purchase insurance through the Connector. There is no direct fiscal impact to the state from these provisions.

Section 6 establishes the Connecticut Individual Health Reinsurance Pool. As this Pool is to be funded entirely on industry assessments, no direct fiscal impact to the state results.

Sections 7 and 27 establish refundable tax credits for employers offering employees insurance through the Connector. This will result in a General Fund revenue loss from the corporation business tax and the personal income tax of at least $200 million per year beginning in FY09. The bill is expected to result in a further cost to the Department of Revenue Services of $665,000 in FY09 and $220,000 in FY10 to administer and audit the credit program.

Section 8 establishes a health savings account program for families with incomes under 300% of the Federal Poverty Level (FPL) who are enrolled in a high deductible insurance plan. The Connector must make payments to these accounts annually on a sliding fee scale specified in the bill. These payments range from $400 to $1,500 annually. It is not known how many eligible health savings accounts may be established. However, given the subsidy levels specified in the bill, the Connector will incur a significant annual cost. The bill specifies that the administrator of the Connector will receive funds from the Comptroller to make these payments. Therefore, the General Fund would bear these costs. **Section 33** appropriates an unspecified amount of funding to OHCA to carry out this section.

Section 9 establishes a premium subsidy program for families with incomes under 400% FPL who currently have private insurance. The Connector must reimburse eligible families quarterly according to a sliding fee scale specified in the bill. These payments range from $600 to $3,600 annually depending on income and family size.

According to the United States Census Bureau 2007 Current Population Survey, there are approximately 170,000 individuals (68,000 households) under 300% FPL in Connecticut who are covered by private insurance. The family size and income distribution is not known. It is also not known how many of these households have private insurance that meets the terms specified in the bill. However, assuming that half of the households are enrolled in the required insurance, and receive an average premium subsidy ($2,100), the Connector would incur an annual cost of approximately $71,400,000.

The bill specifies that the administrator of the Connector will receive funds from the Comptroller to make these payments. Therefore, it is assumed that the General Fund would bear these costs. **Section 34** appropriates an unspecified amount of funding to OHCA to carry out this section.

Section 10 makes changes to the small employer group community rating system. These changes are not anticipated to have a direct fiscal impact on the state.

Section 11 requires the Department of Public Health (DPH) to establish and offer incentives for physicians who provide services for at least four hours to specified health care organizations. Resulting costs would depend upon the spectrum of incentives offered and the number of physicians willing to donate four hours, which cannot be determined in advance. However, it is likely that the cost of a comprehensive program would exceed $100,000.

Section 12 requires the DPH to expand the Connecticut Tobacco Use Prevention and Control Plan, by 1/1/09, to offer, within available appropriations, smoking cessation medications and supplies, including but not limited to nicotine replacement therapy. $1,000,000 is appropriated for this purpose within **Section 30**. Additionally, **Section 29** transfers the sum remaining in the Tobacco and Health Trust Fund on 7/1/08 to the General Fund, of which $20,000,000 must be used by the DPH for a CT Tobacco Use Prevention and Control Plan. This will reduce the principal in the THTF by an estimated $29.2 million, and correspondingly increase the resources of the General Fund.

To the extent that effective smoking cessation programming reduces the incidence of tobacco related adverse medical consequences, future reductions in expenditures under public health care programs may ensue.

Section 13 requires the Health Care Reform Commission to establish a six-member subcommittee on Healthy Lifestyles. OHCA must contract for a marketing campaign, within available

appropriations. **Sections 38 and 39** appropriate $250,000 in FY09 and $260,000 in FY10 for the purposes of this subcommittee.

Section 14 requires the Health Care Reform Commission to establish the "Connecticut Health Quality Partnership" to collect, analyze and disseminate various health data. The Partnership may seek funding from federal and private sources. **Section 36** appropriates $500,000 to OHCA for one-time start up funds for the Partnership.

Sections 15 and 17 require OHCA to make various determinations concerning the number of uninsured in the state. **Section 37** appropriated $250,000 in FY09 to conduct the study and survey on Connecticut's uninsured.

Section 16 requires the DPH to identify and evaluate current programs that provide services to residents of this state who are uninsured. The department must submit a report, by 1/1/09, identifying those programs that are likely to experience a decrease in utilization due to the implementation of the Connecticut Healthy Steps program, to the extent feasible. A significant cost will be incurred by the Department to comply with these requirements.

Section 18 requires the Department of Social Services (DSS) to establish an excess cost reinsurance program that disregards (1) assets equal to the amount of premiums an insured paid for an affordable health care plan for the two years before his or her Medicaid application and (2) as income the amount of premiums an insured paid for an affordable health care plan in the year he or she applies for Medicaid.

This provision would enable additional people to enroll in the Medicaid program. It is not known how many applicants to the Medicaid plan have applicable premiums paid that would be used as income disregards. However, it is likely that the additional costs would be significant.

Section 19 requires DSS to seek a federal waiver to receive reimbursement for costs incurred under sections 8 and 9 and to establish a Medicaid funded excess cost reinsurance program. Should the waiver be granted, the state would receive 50% reimbursement for the costs incurred by the Connector under sections 8 and 9. The state cost for the excess cost reinsurance program will be dependent upon the structure of the waiver submitted to the federal government, which is not now known. **Section 32** appropriates $1,000,000 to DSS to obtain consulting services to establish this section.

Section 20 requires DSS to develop a plan to improve the coordination of health care services for some or all of the aged, blind or disabled Medicaid beneficiaries. These individuals currently receive unmanaged, fee-for-service benefits, with an estimated FY09 cost of $1,400,000,000 (for approximately 74,000 clients). Such a system may be able to provide more coordinated care as well as reduce the annual $18,900 cost per client. The potential savings will be dependent upon the system developed. For purposes of illustration, each 5% savings achieved would result in annual savings of approximately $70,000,000.

Section 21 requires DSS to allow Medicaid fee-for-service beneficiaries to enroll in the managed care plans available under the HUSKY plans. The impact of this provision is uncertain. Integrating these higher cost individuals ($18,900 per client annually as compared to $2,600 annually for HUSKY A enrollees) will likely drive up the capitated rate paid by DSS to the managed care organizations (MCO's). However, as noted in the previous section, more coordinated care may reduce the annual medical costs for these clients.

Section 22 specifies that the income limits for the State Administered General Assistance program be tied to those in effect for the Medicaid medically needy category as of June 30, 2008. This section continues current practice, and allows the SAGA program to remain unchanged, given the medically needy income limit change implemented in section 23 of this bill.

Section 23 requires DSS to increase the Medicaid medically needy

income limit to 100% FPL. This change is expected to increase Medicaid eligibility by 13,600 individuals, at a cost of $47,400,000 in FY09. These costs would be reimbursed 50% by the federal government under the Medicaid program.

This section also allows DSS to impose co-payments on individuals who utilize the emergency room of a hospital to access services of a nonemergency nature. Should this policy reduce the use of emergency room services under the Medicaid program, a savings to the state may result.

Section 24 establishes a continuous eligibility policy for children and adults in the HUSKY plan. This change is estimated to cost at least $2,900,000 annually. Although the costs for the children would be reimbursed 50% by the federal government under the Medicaid program, it is not clear whether the additional costs of the adult would be reimbursable under current federal policy.

Section 25 limits the administrative costs of HUSKY MCO's to 10%. DSS may exclude from this cap disease management or value added clinical programs, but specifically may not exclude utilization management, claims, member services or other non-clinical functions. The impact of this change is uncertain. Although the cap may reduce what the state reimburses the MCO's for administrative costs, limiting the MCO's ability to conduct utilization review may increase the medical service costs. The administrative cap may also reduce the MCO's ability to meet state and federally required reporting mandates.

Section 26 requires, to the extent federal law permits, a Connecticut employer offering its employees health care benefits to offer all employees, regardless of their compensation level, benefits or premium contributions of equivalent value. This is not expected to have any direct fiscal impact on the state.

Section 28 clarifies the authority of HRA with regard to sections 3 and 4 of the bill and has no direct fiscal impact.

Sections 29, 30 and 32-41 appropriate funds as detailed above.

Section 31 appropriates $1.6 million to the DPH in FY 09 to allow the agency to provide eight $200,000 grants to train employers to educate employees about the financial and health benefits of making lifestyle choices that promote good health.

To the extent that promotion of healthy lifestyle choices reduces the incidence of obesity and related adverse medical consequences, future reductions in expenditures under public health care programs may ensue.

Section 42 repeals law that prohibits guaranteed eligibility in the Medicaid program. It is not clear that by repealing the prohibition the bill restores the guaranteed eligibility policy. Should this policy be restored, it is estimated that the Medicaid program will incur additional expenses of approximately $2,000,000 annually.

Note: sHB 5021 (the FY09 budget adjustment, as favorably reported by the Appropriations Committee) does not contain any funding related to the costs in this bill nor the additional appropriations made in this bill.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sHB 5721

AN ACT ESTABLISHING THE CONNECTICUT HEALTHY STEPS PROGRAM.

SUMMARY:

Beginning July 1, 2008, this bill establishes the Connecticut Healthy Steps Program, which consists of numerous health insurance requirements, HUSKY program changes, and public health initiatives.

It establishes the (1) Health Care Reform Commission, (2) Connecticut Connector program, (3) Connecticut Individual Health Reinsurance Pool, (4) Healthy Lifestyles subcommittee, (5) Connecticut Health Quality Partnership, (6) a tax credit for employers who offer health insurance to employees, (7) a health savings account incentive program, and (8) a premium subsidy program. It authorizes a copayment for Medicaid recipients who use an emergency room for non-emergent services, and requires a study of Connecticut's uninsured residents and health care programs available to them.

It requires the Health Reinsurance Association (HRA) to administer the Connecticut Connector and outlines HRA's duties as administrator. It also requires HRA to make affordable health care plans, for which the bill sets certain policy requirements and benefit standards, available to certain individuals and employers.

The bill makes numerous appropriations to carry out its purposes.

EFFECTIVE DATE: Various, see below.

§§ 2 & 35 — HEALTH CARE REFORM COMMISSION

The bill establishes a permanent 14–member Health Care Reform Commission as an independent, nonprofit body in the Office of Health

Care Access (OHCA) for administrative purposes.

By April 1, 2009, the commission must design "affordable health care plans" (see § 4), which must receive the insurance commissioner's approval and be available for sale to employers by January 1, 2010. The bill exempts the affordable health care plans from the statutory minimum benefit standards that apply to comprehensive health care plans.

By October 1, 2010, the commission must report to the Insurance and Real Estate Committee identifying the effect mandating health insurance benefits has on private employers' health care premiums.

Beginning January 1, 2010 and annually afterward, the commission must provide recommendations to the General Assembly about the Connecticut Healthy Steps Program and improvements to the health care system, including cost controls.

The bill also requires the commission to:

1. adopt rules for the collecting fees from each insurer selling products through the Connector to support administration costs;

2. explore incentives to encourage people to use health insurance responsibly;

3. determine the fee, as a percentage of premium, that insurance producers must be paid for referring people to the Connector for affordable health care plans;

4. by April 1, 2009, develop a plan for collecting premiums from people and employers purchasing coverage through the Connector, imposing late payment penalties, and terminating coverage for not paying premiums owed;

5. establish a subcommittee on healthy lifestyles;

6. by July 1, 2009, establish the Connecticut Health Quality

Partnership; and

7. determine whether residents should be required to have health insurance if the number of uninsured people has not decreased 50% by January 1, 2014.

Commission members include the Comptroller, social services (DSS), public health (DPH), OHCA, and insurance commissioners or designees, and nine members appointed, as follows, by the:

1. Connecticut Medical Society (CMS), Connecticut Hospital Association (CHA), Connecticut Association of Health Plans (CAHP), and Connecticut Business and Industry Association (CBIA), who each appoint one;

2. Senate president pro tempore and House speaker, who each appoint one consumer advocate; and

3. governor, who appoints three. One must be an owner, senior manager, or human resource director of a Connecticut business that employs more than 50 people in Connecticut and another must be a senior manager or human resource director of a labor union that offers a Taft-Hartley plan (a type of employee benefit plan created under federal law). The bill does not designate the governor's third appointee.

The initial nine appointees serve staggered terms, as follows: (1) CHA, CAHP, and CBIA appointees serve for three years; (2) CMS, Senate president pro tempore, and House speaker appointees serve for two years; and (3) gubernatorial appointees serve one year. After the initial terms expire, subsequent appointees serve three-year terms and members may be reappointed. The appointing authority must fill any vacancy for the unexpired term. Members are not compensated but are reimbursed for their expenses.

The bill requires the commission to meet as often as necessary to complete its work, but at least quarterly, and it can hire consultants and staff within available appropriations.

The bill appropriates $500,000 for FY 09 to OHCA for the commission.

EFFECTIVE DATE: July 1, 2008

§§ 3, 40, 41 — CONNECTICUT CONNECTOR

The bill establishes a program called the Connecticut Connector. It requires HRA to administer the Connector, through which eligible people and employers may purchase affordable health care plans. HRA must meet with the commission as the commission determines appropriate.

General HRA Requirements

The bill requires HRA to:

1. screen applicants for eligibility for incentive programs the bill establishes (see §§ 8 & 9) and to purchase through the Connector;

2. pay insurance producers for referring small employers and individuals to the Connector who qualify for and purchase affordable health care plans;

3. provide the creditable coverage notices required under the federal Health Insurance Portability and Accountability Act (HIPAA);

4. market the health plans available though the Connector to potential purchasers;

5. provide information to applicants who may be eligible for Medicaid or HUSKY A or B, including how to apply for those programs;

6. determine employer eligibility for the tax credit program the bill establishes and issue, as appropriate, tax credit eligibility certificates;

7. receive money from the comptroller and pay individuals and

employers eligible under the health savings account incentive and premium assistance programs the bill establishes; and

8. collect fees from health insurers and HMOs licensed in Connecticut, excluding Medicaid managed care health plans, based on rules the commission adopts, to support administration costs and any other functions the commission deems appropriate. The fees must be based on total covered lives. "Covered lives" includes all people who are (a) covered under an individual or group health insurance policy or certificate issued or delivered in Connecticut or (b) protected in part by a group stop loss insurance policy or certificate issued or delivered in Connecticut and purchased by a group health insurance plan that is subject to the federal Employee Retirement Income Security Act.

By July 1, 2010, and annually afterward, HRA must provide data and reports to the commission and the General Assembly that include (a) the number and demographics of previously uninsured people covered through the Connector, by type of policy; (b) the Connector's per capita administrative costs; (c) any recommendations for improving service, health insurance policy offerings, and costs; and (d) any other information the commission requires.

HRA Requirements for Individual Insurance

For individual insurance, the bill requires HRA to:

1. notify insurers, with the commission's assistance, of the opportunity to make affordable health care plans available for sale through the Connector;

2. process applications for individual insurance, with the commission's assistance;

3. publish easy-to-understand material for prospective purchasers comparing the costs and benefits of all plans;

4. help applicants to (a) understand the plans' benefits and (b) select a plan that reflects their needs and income (the bill specifies this does not require an insurance agent license);

5. work with the insurers selling products through the Connector to develop a uniform tool for collecting applicant or enrollee data needed for underwriting, enrollment, and other purposes that receives the insurance commissioner's approval;

6. collect premiums from employers and individuals, as well as subsidies from the state, and remit them to enrollees' health plans;

7. notify insureds when their premiums are late and disenroll them or impose late penalties as specified by law; and

8. provide information about HRA benefits to applicants denied coverage because of underwriting concerns (i.e., are high risk).

HRA Requirements for Small Employer Plans

For small employer plans, the bill requires HRA to:

1. solicit and select two or more third party administrators to administer affordable health care plans;

2. file and obtain Insurance Department approval for affordable health care plans for small employers;

3. perform, or contract for, all functions necessary to offer and service affordable health care plans, including premium collection, actuarial work to develop rates, paying agents, developing application forms, enrolling people, and obtaining capital for reserves and losses; and

4. price the affordable health care plans to break even each year and deposit any surplus into a separate, nonlapsing General Fund account. The insurance commissioner must use the account to cover future losses or to reduce future premiums, as

the commission deems appropriate. Losses funded through borrowing from the account must be paid back from future premium increases.

Appropriations

The bill appropriates for FY 09 to the Insurance Department (a) $1 million for the Connector's start-up costs, including web site development, a premium subsidy administration system, marketing, communications, administrative functions, and other technology and equipment and (a) $1.5 million to operate and administer the Connector and market affordable health care plans.

The bill appropriates $1 million from for FY 10 to the Insurance Department to operate and administer the Connector and market affordable health care plans. (Usually an appropriation from a future fiscal year has a later effective date.)

EFFECTIVE DATE: July 1, 2008

§ 4 — AFFORDABLE HEALTH CARE PLANS

The bill requires HRA to offer affordable health care plans to individuals and employers in accordance with standards the commission sets. An employer purchasing an affordable health care plan through the Connector may offer its employees that plan only, or may offer it as a choice alongside (1) comprehensive health care plans or (2) a high deductible plan with a health savings account. If an employer offers plans in addition to the affordable health care plan and allows its employees to select a plan, it may offer the same percentage or dollar contribution for all plans (presumably the same as it does for the affordable health care plan).

Benefits

The bill exempts affordable health care plans from the minimum coverage or benefits required in Connecticut laws for health insurance. It requires these plans to include, as minimum benefits:

1. coverage of physicians, clinics, ambulatory surgery, laboratory

and diagnostic services, in-patient and out-patient hospital care, and medically necessary prescription drugs for physical or mental health;

2. out-of-pocket costs, including copayments, deductibles, and coinsurance, that reflects family income (see below);

3. no deductible for well-child visits, prenatal care, and a person's first two physician visits annually; and

4. a lifetime benefits maximum of at least (a) $500,000 or (b) if an excess cost reinsurance program is not available through DSS, $1 million.

Premiums, Rates, Loss Ratio

The bill prohibits premium for an affordable health care plan to cost more than $200 a month, on average, for an eligible enrollee or dependent. The Insurance Department must annually adjust this amount for inflation based on average health insurance premium increases. The commission must adjust the plan benefit design if HRA cannot structure an employer plan, or no insurers will sell a plan, for this amount.

Rates for affordable health care plans offered to small employers (50 or fewer employees) must be established on the basis of a community rate, adjusted by characteristics as allowed by law (see § 10 below).

Individual plans available for through the Connector must:

1. be priced to reflect an insurer's reduced administrative cost because the Connector is performing administrative functions;

2. have a minimum loss ratio (claims incurred to premiums earned) of at least 75% on average over any three-year moving period, where "loss" excludes administrative services (e.g., enrollment, marketing, premium collection, claims adjudication, member services) and profit;

3. have rates established on the basis of a community rate, adjusted to reflect the person's age, gender, health status (excellent or good), family composition, county, and tobacco use; and

4. be renewable at the insured's option.

Individual Applicant with Preexisting Condition

The bill permits an insurer or HMO offering insurance through the Connector to an applicant for an individual affordable health care plan with an identified preexisting condition (a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 12 months immediately preceding the coverage effective date), to

1. deny coverage to the applicant;

2. impose an additional deductible up to $500 for the preexisting condition;

3. impose a preexisting condition exclusion that excludes coverage for the preexisting condition for up to 12 months from the effective date of the person's coverage;

4. issue an exclusionary rider that permanently excludes the condition, narrowly defined, from coverage; or

5. obtain reinsurance coverage for the preexisting condition through the Connecticut Individual Health Reinsurance Pool, which the bill establishes (see § 6).

Pool reimbursement is limited to the actual paid, reinsured benefits between $5,000 and $75,000 for the first 12 months of coverage under an affordable health care plan. These amounts must be annually indexed to the consumer price index for medical care. The pool's board of directors must determine the reinsurance premium rates in accordance with statutory provisions (CGS § 38a-570).

Creditable Coverage

The bill specifies that Connector health plan coverage is creditable coverage for purposes of HIPAA. (Creditable coverage is the time a person was covered under a prior plan that counts toward any preexisting condition coverage exclusion in a policy currently covering the person.)

EFFECTIVE DATE: March 1, 2010

§ 5 — ELIGIBILITY FOR AFFORDABLE HEALTH CARE PLANS

Individual Eligibility

The bill establishes the eligibility criteria for a person applying for individual coverage through the Connector.

An individual applicant must show proof of Connecticut residency, such as voter registration, tax filings, a utility bill, or other documentation that the insurance commissioner deems satisfactory.

An eligible person does not have access to employer-sponsored coverage under which the employer pays at least 50% of the person's, and his or her dependents', coverage and (1) has been uninsured for at least six months or (2) has been uninsured for less than six months and lost coverage due to a major life event. Major life events include:

1. loss of coverage due to job loss;
2. death of, or abandonment by, a family member who had provided coverage;
3. loss of dependent coverage because a spouse became eligible for Medicare due to age or disability;
4. losing coverage as a dependent under a group comprehensive health care plan due to age, divorce, or other status changes;
5. exhausting coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA);
6. extreme economic hardship on the part of either the employee or

the employer, as HRA determines in accordance with specific measurable criteria the commission defines; and

7. any other events the commission may specify.

Employer Eligibility

The bill establishes the eligibility criteria for an employer applying for group coverage through the Connector. An eligible employer is one that:

1. has 50 or fewer employees,

2. has not offered a comprehensive health insurance plan to any employee for at least six months,

3. will contribute at least (a) 70% for employee coverage and (b) 50% of employee and dependent coverage under the least expensive plan available through the Connector for any one of an employee's dependents; and

4. attests to HRA that at least 90% of its employees either have coverage through another plan or will enroll in a plan through the Connector.

EFFECTIVE DATE: January 1, 2010

§ 6 — CONNECTICUT INDIVIDUAL HEALTH REINSURANCE POOL

The bill establishes, as a nonprofit entity, the Connecticut Individual Health Reinsurance Pool. All insurers, HMOs, and hospital or medical service corporations authorized to transact health insurance in Connecticut on and after March 1, 2010 must be pool members. The board of directors for the existing Connecticut Small Employer Health Reinsurance Pool must administer the pool.

Plan of Operation

The board must submit a plan of operation to the insurance commissioner by May 30, 2010 and any necessary amendments afterward. After notice and a hearing, the commissioner must approve

the plan if he finds it assures the pool's fair, reasonable, and equitable administration and provides for sharing of pool gains or losses on an equitable, proportionate basis.

The plan of operation takes effect with the commissioner's written approval, consistent with the date on which coverage is made available. If the board fails to submit a suitable plan by August 28, 2010, or appropriate amendments when needed, the commissioner must adopt a plan of operation or amendments. He must provide notice and a hearing before doing this.

The plan must set procedures for:

1. the handling and accounting of pool assets and money and for an annual fiscal report to the commissioner;
2. selecting and determining the powers and duties of an administrator;
3. reinsuring risks;
4. collecting assessments from members to provide for claims the pool reinsures and administrative costs for the assessment period;
5. imposing interest penalties for when assessments are paid late; and
6. additional matters at the board's discretion.

Pool Powers

The pool has the general powers and authority given licensed health insurance companies under Connecticut law and specific authority to:

1. enter into necessary contracts, including, with the commissioner's approval, those with (a) other states to jointly perform common functions, or (b) people or entities for administrative purposes;

2. sue or be sued, including taking legal action to recover assessments for, on behalf of, or against members;

3. take necessary legal action to avoid improper claims payment;

4. define the kinds of health coverage products to be reinsured and issue reinsurance policies;

5. establish rules, conditions, and procedures for reinsuring members' risks;

6. establish rates, rate schedules, rate adjustments, rate classifications, and other appropriate actuarial functions;

7. assess members, including making reasonable interim assessments (interim assessments must be credited as offsets against regular assessments due after the close of the fiscal year);

8. appoint legal, actuarial, and other committees for technical assistance purposes; and

9. borrow money. Notes or other pool indebtedness not in default are legal investments for insurers and may be carried as admitted assets.

Reinsuring Coverage

Any member can use the pool to reinsure coverage of an eligible individual, as defined in the pool's plan of operation, who has an identified preexisting condition. The pool reimbursement for a preexisting condition is limited to the actual paid, reinsured benefits between $5,000 and $75,000 for the first 12 months of coverage under the person's reinsured individual affordable health care plan. The pool's board of directors must determine reinsurance premiums based on recommendations of its actuarial committee in accordance with law. The bill specifies that amounts must be annually indexed to the consumer price index for medical care (it is unclear if this refers to the reinsurance benefits, premiums, or both).

Any reinsurance placed with the pool must have the commissioner's approval. The commissioner may adopt regulations to implement these reinsurance requirements.

Reinsurance Premium Rates

The pool must establish reinsurance premium rates in accordance with regulations the commissioner adopts.

The board may modify, if appropriate, the premium rates charged to an HMO that is subject to requirements that limit the amount of risk it can cede to the pool to reflect these limits.

Assessments

After each fiscal year closes, the pool administrator must determine the year's net premiums, pool administration expenses, and incurred losses, taking into account investment income and other appropriate gains and losses. "Net premiums" means health insurance premiums minus administrative expense allowances.

To recoup net losses, the pool's board must assess members (1) in proportion to their share of total health insurance premiums earned from plans covering individuals for the most recent calendar year, or (2) other equitable basis the plan of operation permits. Health insurance premiums and benefits a member paid that are less than an amount the board determines to justify the cost of collection will not be considered for purposes of determining assessments.

Federally approved HMOs must be assessed based on an "assessment adjustment formula" that the board adopts and commissioner approves. The formula must recognize federal restrictions on HMOs and be approved and adopted before the pool's first anniversary.

If losses are not recouped when the pool has collected assessments totaling 5% of premiums on individual plans, the board must impose additional assessments on all pool members in proportion to their respective shares of the total health insurance premiums earned in

Connecticut during that calendar year from other individual and group plans and arrangements, excluding any individual Medicare supplement policies. The bill prohibits assessments to any one member from exceeding 40% of the total assessment for the pool's first fiscal year and 50% of the total assessment for the second fiscal year.

If the assessments exceed actual losses and administrative expenses, the board may use the excess plus earned interest to offset future losses or reduce pool premiums. "Future losses" includes reserves for incurred, but not reported, claims.

The board must determine annually each member's portion of pool participation based on annual statements and other reports it deems necessary for the member to file.

The board may defer all or part of an HMO's assessment if (1) payment would harm the HMO's ability to meet contractual obligations or (2) the member has written, and totally reinsured, a disproportionate number of individual affordable health care plans. If an assessment is deferred, the board may assess that amount against other members, although the HMO getting the deferral remains liable to the pool. The board may impose conditions on a deferment.

Qualified Immunity

Pool members are not civilly or criminally liable by virtue of their participation in the pool or as a result of any required collective action, such as establishing rates, forms, or procedures.

Pool board members, committee members, officers, or employees are held harmless and indemnified against all legal liability and costs, including judgments, settlements, fines, penalties, expenses, and reasonable attorney fees. But they are not indemnified if they are found to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance, or reckless disregard of their duties. Indemnification costs are prorated among and paid by the members.

Insurance Commissioner Consultants

The insurance commissioner may retain actuarial consultants necessary to carry out his responsibilities, and the pool must pay the expenses.

EFFECTIVE DATE: March 1, 2010

§§ 7 & 27 — EMPLOYER TAX CREDIT FOR OFFERING INSURANCE

The bill establishes refundable tax credits for employers offering employees, through the Connector, (1) an affordable health care plan or (2) other insurance with benefits that are at least equivalent to those in the affordable health care plans. The credits vary depending on the type of plan offered and who they cover (see below). The credits apply against any corporation business tax the employer owes.

To qualify for the credit, an employer must submit to the Connector (1) a copy of its health insurance plan, (2) documentation of its employees' wages, and (3) proof of its premiums paid. It must obtain a tax credit eligibility certificate from the Connector and pay at least (1) 70% of the employee coverage costs or (2) 50% of the employee and dependent coverage costs for full-time employees' dependent coverage costs.

The bill requires the Connector to (1) determine whether to certify that an employer is eligible for a tax credit within 30 days of receiving all relevant information from the employer and (2) provide information to employers seeking certification assistance.

The bill authorizes an employer that is a limited liability company, limited liability partnership, limited partnership, or S corporation to distribute its available tax credit to its members, who may use the credit against any income tax they owe.

If the tax owed is less than the value of the tax credit, the state must refund any unused credit to the employer or member as appropriate. The bill requires the allowable credits to be indexed annually to the consumer price index for medical care.

The bill defines employer as any person, firm, business, educational institution, nonprofit agency, corporation, limited liability company, or any other business entity that, on at least 50% of its working days during the last 12 months employed:

1. 10 or fewer employees;

2. 11 to 50 employees, at least 30% of whom the employer paid annualized wages of up to 300% of the federal poverty level (FPL) for a family of three ($52,800); or

3. more than 50 employees, at least 75% of whom the employer paid annualized wages up to 185% FPL for a family of three ($32,560).

Under the bill, employees must work at least 35 hours a week to be full-time and less than 35 hours a week to be part-time. Employees must be employed or reside in Connecticut and cannot be temporary or seasonal.

The table below shows the annual per-employee tax credit for employers offering health insurance to all full-time, but not all part-time, employees.

If the plan covers:	***Then the credit equals:***
An employee	20% of the cost of providing health care benefits, up to $800.
An employee and one other person	20% of the cost, up to $1,600.
An employee and family	20% of the cost, up to $2,400.

The table below shows the annual per-employee tax credit for employers offering health insurance to all full- and part-time employees.

If the plan covers:	***Then the credit equals:***

An employee	30% of the cost of providing health care benefits, up to $1,200.
An employee and one other person	30% of the cost, up to $2,400.
An employee and family	30% of the cost, up to $3,600.

EFFECTIVE DATE: October 1, 2008 for determining employer eligibility and January 1, 2010, applicable to income years beginning on and after that date, for claiming the credit.

§§ 8 & 33 — HEALTH SAVINGS ACCOUNT INCENTIVE PROGRAM

The bill establishes a health savings account (HSA) incentive program. To be eligible, a person must have (1) family income up to 300% FPL, (2) been a Connecticut resident at least six months, and (3) an HSA and a high-deductible plan as defined in federal law.

The bill requires the Connector to contribute to a person's HSA, annually by January 30, an amount based on a sliding income scale and amount of HSA contributions the person made or received in the prior calendar year. But the Connector does not have to make a contribution if the person's HSA balance exceeds the deductible required under his or her high deductible health plan. HRA must establish procedures for people to claim payments.

The table below provides the Connector's required contributions, by family income.

Family's Prior Year Contribution	***Connector Contribution***
Family Income = 200% or Less FPL	
$2,500 (individual)	$500
$3,750 (family of two)	$1,000
$5,000 (family of at least three)	$1,500
Family Income = 200% to 300% FPL	

$2,500 (individual)	$400
$3,750 (family of two)	$800
$5,000 (family of at least three)	$1,200

The bill requires the income amounts to be indexed annually to the consumer price index for medical care.

The bill appropriates an unspecified amount from the General Fund for FY 09 to OHCA for the HSA incentive program.

EFFECTIVE DATE: October 1, 2009, except for the appropriation, which is effective July 1, 2008.

§§ 9 & 34 — PREMIUM SUBSIDY PROGRAM

The bill establishes a premium subsidy program beginning October 1, 2009. To be eligible, a person must:

1. have family income of up to 300% FPL;

2. not own an HSA either individually or as part of a family; and

3. have health care coverage under (a) an affordable health care plan purchased through the Connector (which are not required to be available until January 1, 2010), (b) an employer-sponsored group health insurance policy for which the person annually pays at least $500 in premiums if single and at least $1,000 if covered by a family plan, or (c) a nonemployer-based plan purchased through the individual market or the Connector. (A person could be both single and covered under a family plan if covering dependent children. Perhaps "single" means covered under an employee-only plan.)

The bill requires the Connector to reimburse eligible people quarterly for premiums they paid in the preceding quarter based on a sliding income scale.

For a family with income of 200% FPL or less, the Connector must reimburse 80% of their premium share, up to $300 per quarter for an individual, $600 for an individual plus one dependent, or $900 for a family. For a family with income between 200% and 300% FPL, the Connector must reimburse 60% of their premium share, up to $150 per quarter for an individual, $300 for an individual plus one dependent, or $450 for a family.

The Connector must adjust reimbursement amounts if the person purchases individual:

1. health insurance for which premiums were based on his or her age, gender, and residence county, to reflect differences in premiums for each of these rating classifications and

2. coverage through HRA, to increase the amounts specified above by 20%.

The bill requires HRA to establish procedures for people to claim payments.

The bill appropriates an unspecified amount from the General Fund for FY 09 to OHCA for the HSA incentive program.

EFFECTIVE DATE: October 1, 2009, except for the appropriation, which is effective July 1, 2008.

§ 10 — SMALL EMPLOYER RATING CHARACTERISTICS

Under current law, insurers and HMOs must use adjusted community rating when developing premium rates for small employer groups. Community rating is the process of developing a uniform rate for all enrollees. An adjusted community rate is one that modifies the community rate by one or more classifications specified in statute.

The classifications allowed by law are age, gender, location, industry classification, group size, family composition, and administrative cost and profit reduction savings resulting from administering or writing an association group plan or a Municipal

Employee Health Insurance Plan (MEHIP).

For small employer plans delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2009, the bill adds as a permissible classification participation in a nonsmoking program that complies with HIPAA's nondiscrimination rules (rates cannot be contingent on health factors).

EFFECTIVE DATE: January 1, 2009

§ 11 — DPH PHYSICIAN INCENTIVES

The bill requires DPH to establish and offer incentives for physicians in private practice who provide at least four hours of services to federally qualified health centers, community health centers, community mental health centers, or school-based clinics. (It does not specify how often the four-hours must occur, e.g., monthly, weekly.) The incentives may include (1) reduced cost medical malpractice insurance that DPH offers or arranges for, (2) loan forgiveness from state-funded colleges and universities, and (3) partial payment of educational loans.

EFFECTIVE DATE: July 1, 2008

§§§ 12, 29, 30 — SMOKING CESSATION

The bill requires DPH, by January 1, 2009, to expand the Connecticut Tobacco Use Prevention and Control Plan to offer, within available appropriations, smoking cessation medication and supplies, including nicotine replacement therapy. The bill appropriates $1 million from the General Fund for FY 09 to DPH for this expansion.

It requires transferring the remaining Tobacco and Health Trust Fund balance to the General Fund. Of this amount, DPH must use $20 million for the Connecticut Tobacco Use and Prevention Control Plan.

EFFECTIVE DATE: July 1, 2008

§§ 13, 31, 38, 39 — HEALTHY LIFESTYLES SUBCOMMITTEE, GRANT PROGRAM

The bill requires the Health Care Reform Commission to establish a six-member subcommittee on Healthy Lifestyles. The OHCA commissioner must select the members from Commission's members.

By March 1, 2010, it must (1) develop a marketing campaign educating the public on basic ways to ensure good health and the consequences of poor health and (2) make recommendations to the General Assembly about incentives to encourage personal responsibility in making healthy lifestyle choices.

The subcommittee must meet at least quarterly. It may, within available appropriations, hire consultants to assist with its responsibilities. OHCA must, within available appropriations, contract with one or more entities to implement the required marketing campaign.

The bill appropriates $1.6 million for FY 09 to DPH to provide $200,000 grants to each of eight different groups representing employers. DPH must establish regulatory criteria and procedures for awarding the grants, which the groups must use to train employers to educate employees on the financial and health benefits of making lifestyle choices that promote good health, including regular exercise and maintaining a healthy weight.

The bill appropriates $250,000 for FY 09 and $260,000 for FY 10 to OHCA for the healthy lifestyle subcommittee's purposes.

EFFECTIVE DATE: January 1, 2009, except for the FY 09 appropriations, which are effective July 1, 2008, and the FY 10 appropriation, which is effective July 1, 2009.

§§ 14 & 36 — CONNECTICUT HEALTH QUALITY PARTNERSHIP

The bill requires the Health Care Reform Commission to establish the "Connecticut Health Quality Partnership" by July 1, 2009 and appoint at least eight people to it. The appointees must include public and private sector representatives, including health insurers, hospital associations, physicians, DPH, DSS, and Medicaid managed care

organization (MCOs), and up to two consumer advocates who are not affiliated with any other member. The commission must assign staff to assist the partnership with its responsibilities.

The partnership must:

1. collect and analyze insurance and Medicaid claims data and other data concerning the quality of care and services health care providers render to support quality improvement initiatives and help consumers make informed provider choices;

2. provide comparative data to providers concerning the quality of their performance relative to their peers;

3. collect and analyze data about hospital-acquired infections from hospitals for the purpose of tracking, reporting, and reducing infection rates;

4. collect and analyze data from other providers as necessary;

5. annually select state-wide quality improvement initiatives and encourage all health plans to adopt them with the same goals and metrics;

6. seek funding from private and public funding; and

7. seek National Committee for Quality Assurance accreditation as a "quality plus program" by July 1, 2013.

The bill appropriates $500,000 for FY 09 to OHCA as start-up funds for the partnership, contingent on the partnership obtaining commitments from at least six members to contribute dues sufficient to assure the partnership's financial viability.

EFFECTIVE DATE: July 1, 2008

§§ 15, 17, 37 — CONNECTICUT'S UNINSURED

By January 1, 2009, and every five years afterward, the bill requires OHCA to determine the number of uninsured Connecticut residents.

It requires the Health Care Reform Commission to determine whether residents should be required to have health insurance if, by January 1, 2014, the number of uninsured has not decreased by 50% from OHCA's 2009 determination. By January 1, 2015, the commission must report its findings to the Insurance and Real Estate Committee.

Annually, beginning December 31, 2009, it requires OHCA to conduct a survey to determine the number of Connecticut employers providing health insurance to their employees residing in Connecticut. OHCA must annually report its findings to the Insurance and Real Estate Committee beginning January 1, 2010.

OHCA must use the data regarding any decrease in the number of uninsured residents to recommend to DSS corresponding decreases in the disproportionate share payments to hospitals. By law, DSS determines the amount of such payments based on information from OHCA. The disproportionate share program is a joint federal/state program designed to reimburse hospitals for care provided (1) to a high volume of Medicaid and other low-income patients and (2) for which they are not fully compensated.

The bill appropriates $200,000 for FY 09 to OHCA for conducting the studies and surveys.

EFFECTIVE DATE: October 1, 2008, except for the disproportionate share payments and appropriation provisions, which are effective July 1, 2008.

§ 16 — DPH PROGRAM EVALUATION AND REPORT

The bill requires the DPH commissioner to identify and evaluate existing health care programs that provide services uninsured Connecticut residents. By September 1, 2009, he must report his findings and recommendations to the Public Health and Appropriations committees. The report must identify the (1) programs likely to be used less because of the programs the bill establishes and (2) amount of the utilization decrease, to the extent feasible.

EFFECTIVE DATE: July 1, 2008

§ 18 — EXCESS COST REINSURANCE PROGRAM

The bill requires the DSS commissioner to establish an excess cost reinsurance program that disregards (1) assets equal to the amount of premiums an insured paid for an affordable health care plan for the two years before his or her Medicaid application and (2) as income the amount of premiums an insured paid for an affordable health care plan in the year he or she applies for Medicaid.

It permits the DSS commissioner to adopt regulations to implement the reinsurance program.

EFFECTIVE DATE: July 1, 2008

§§ 19 & 32 — FEDERAL WAIVER TO OFFSET COSTS

The bill directs the DSS commissioner to request a federal waiver of Medicaid rules to (1) obtain federal reimbursement for state expenditures related to the HSA incentive and premium assistance programs and (2) establish an excess cost reinsurance program to ensure that residents enrolled in the Connector's affordable health plan who exhaust their plan's coverage do not have to spend all their assets on health care once this occurs.

It appropriates $1 million for FY 90 to DSS to obtain a consultant to assist with the federal waiver.

EFFECTIVE DATE: July 1, 2008

§ 20 — MEDICAID PRIMARY CARE CASE MANAGEMENT

The bill requires the DSS commissioner to develop a plan to implement a primary care case management (PCCM) program for some or all Medicaid recipients who are aged, blind, or disabled. The commissioner may contract with an administrative services organization to run the program.

The plan must include programs to improve medical service, housing, and social service coordination and for chronic disease

management. It must also include predictive modeling for identifying high-risk, complex, and high-cost Medicaid beneficiaries and provide them with intensive care coordination. The plan must also address (1) provider reimbursement systems in line with the PCCM goals and (2) using and developing outcome measures and reporting requirements to assess and evaluate the chronic care system.

The DSS commissioner must submit (1) the plan, by January 1, 2009, and (2) a plan implementation status report on October 1, 2010, and annually afterward, to the Human Services and Appropriations committees. A status report must include (1) the number of people and providers participating in the PCCM programs, (2) quality improvement and patient satisfaction indicators, (3) annual expenditures and savings associated with the plan, and (4) other information the committees may request.

Under the PCCM model, a beneficiary chooses a primary care provider who is responsible for coordinating the person's care. The provider is paid a separate fee above the regular fees paid for providing direct medical service.

EFFECTIVE DATE: July 1, 2008

§ 21 — AGED, BLIND, AND DISABLED BENEFICIARIES TO VOLUNTARILY ENROLL IN MANAGED CARE

Beginning January 1, 2009, the bill requires the DSS commissioner to allow aged, blind, or disabled Medicaid beneficiaries to enroll in the managed care plans available to HUSKY beneficiaries. (Presumably, beneficiaries would choose between PCCM- or MCO-based care.)

EFFECTIVE DATE: July 1, 2008

§ 22 — SAGA MEDICAID ASSISTANCE RECIPIENTS

Current law requires the DSS commissioner, when determining eligibility for the state-administered general assistance (SAGA) program, to use same income limit DSS uses when determining eligibility for the Medicaid "medically needy" category. (The

medically needy include aged, blind, and disabled individuals and certain others not covered under other Medicaid categories.) The bill requires that he use the Medicaid income limit as used on June 30, 2008.

EFFECTIVE DATE: July 1, 2008

§ 23 — INCOME DISREGARD FOR MEDICALLY NEEDY

The bill requires the DSS commissioner to amend the Medicaid state plan to establish a special income disregard that permits the medically needy with income up to 100% of the federal poverty level to qualify for Medicaid. (An income disregard is an amount of income DSS disregards when determining eligibility.)

EFFECTIVE DATE: July 1, 2008

§ 23 — MEDICAID COPAYMENT FOR IMPROPER EMERGENCY ROOM USE

The bill permits (1) the DSS commissioner, to the extent federal law allows, to impose copayments, up to $25 per visit, for Medicaid recipients who use an emergency room for nonemergency health care services and (2) a hospital to waive a copayment based on hardship or otherwise. It prohibits the commissioner from deducting any copayment imposed from payments due to an emergency room.

The commissioner, after consulting with Connecticut emergency room staff representatives, must define "services of a nonemergency nature." He must give written notice about the copayments, and any applicable DSS policies relating to them, to all Medicaid-eligible people at least 30 days before imposing any.

Under the bill, a person does not have to make a copayment for the first misuse of an emergency room but the emergency room staff must give him or her verbal and written notice, as the commissioner prescribes, advising that copayments will apply to any future nonemergency services and that he or she should seek care for these from other providers.

EFFECTIVE DATE: July 1, 2008

§§ 24 & 42 — CONTINUOUS ELIGIBILITY IN HUSKY

The bill provides for continuous enrollment (CE) for (1) a child determined eligible for HUSKY A or B on or after January 1, 2009, if the child is under age 19 and remains a state resident, and (2) an adult eligible for HUSKY A on or after July 1, 2008, if he or she remains a state resident. Under the bill, CE allows the enrollees to receive ongoing assistance for 12 months even if the parent's or caretaker's financial circumstances change during that time. During this period of CE, the family must comply with federal requirements for reporting information to DSS, such as a change of address.

The bill makes a corollary change by repealing a separate provision that prohibits adults enrolled in Medicaid from being guaranteed eligibility for six months without regard to changes in circumstances that would otherwise render them ineligible. (It does not appear that federal law allows CE for adults, so federal reimbursement may not be possible in these cases.)

EFFECTIVE DATE: July 1, 2008

§ 25 — LIMIT ON MCO ADMINISTRATIVE COSTS FOR HUSKY

Starting July 1, 2009, the bill requires any MCO entering into, renewing, or amending a HUSKY contract to limit its administrative costs to 10% or less of its capitated payments (amount state pays MCO to serve HUSKY clients).

In defining the administrative costs, the bill allows the commissioner to exclude disease management or other value-added clinical programs that the MCOs administer. But he may not exclude any utilization management, claims, member services, or other nonclinical functions.

The DSS commissioner must implement this change while in the process of adopting it in regulation, provided he publishes notice of intent to adopt the regulations in the *Connecticut Law Journal* within 20

days after implementing it. The policies and procedures are valid until the regulations become effective.

EFFECTIVE DATE: July 1, 2008

§ 26 — EMPLOYER PLANS OF EQUIVALENT VALUE

The bill requires, to the extent federal law permits, a Connecticut employer offering its employees health care benefits to offer all employees, regardless of their compensation level, benefits or premium contributions of equivalent value. It specifies that an employer may offer its lower-paid employees a more comprehensive health care benefit plan or a higher level of employer premium contribution than it offers its higher-paid employees.

EFFECTIVE DATE: July 1, 2008

§ 28 — HRA AUTHORITY, MEMBERS, IMMUNITY

It grants HRA specific authority to enter into necessary or proper contracts to carry out its duties with respect to the Connecticut Connector and affordable health care plans.

The bill requires insurers, HMOs, and self-insurers to be members of the HRA as a condition of authority to issue affordable health care plans and participate in the Connector.

The bill grants immunity from liability and lawsuits against certain people and entities for performing duties the bill requires of them concerning the Connector and the affordable health care plans. This immunity is given to (1) any insurer, the HRA, and the residual market mechanism for certain hospital and medical service corporations; (2) their agents or employees; and (3) the insurance commissioner and his representatives.

EFFECTIVE DATE: July 1, 2008

BACKGROUND

Health Reinsurance Association

The legislature originally created HRA to provide comprehensive health insurance to people who cannot obtain insurance from commercial insurers. By law, all Connecticut health insurers and HMOs are (1) HRA members and (2) assessed for its losses. HRA's board of directors is composed of nine individuals selected by the participating member companies.

HRA continues to be Connecticut's insurer of last resort for high-risk individuals. It also HRA serves as the state's acceptable alternative mechanism for complying with the guaranteed issue option in the individual market required under HIPAA. As required by law, HRA offers special health care plans to low-income individuals. Under PA 07-185, §§ 18 to 21, it is also required to offer special health care plans to small employers.

HRA is administered by Pool Administrators, Inc., which is located in Wethersfield, Connecticut.

Related Law

PA 07-2, June Special Session, requires DSS to develop a plan to implement a pilot PCCM program for at least 1,000 HUSKY recipients. Under the pilot, a primary care provider must provide primary medical services to enrollees and arrange for specialty care as needed.

Related Bills

sHB 5536, which the Labor and Public Employees Committee reported, allows small employers to join the state employee health insurance plan.

sHB 5618, which the Human Services Committee reported, makes changes to the HUSKY program and requires DSS to (1) conduct a feasibility and cost study on providing care to HUSKY recipients and (2) monitor the implementation of the PCCM pilot program established by law in 2007.

The Insurance and Real Estate Committee reported:

1. sHB 5709, which permits the sale of individual and group health insurance plans that are exempt from certain mandated benefit requirements;

2. sSB 280, which requires a cost-benefit study of Connecticut's health insurance mandates; and

3. sSB 310, which relates to HRA's responsibility to offer "special health care plans" to small employers.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 15 Nay 2 (03/13/2008)